Supreme Court, U.S.
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In the

Supreme Court of the United States.

OCTOBER TERM, 1994.

LIABILITY INVESTIGATIVE FUND EFFORT, INC.; LEONARD MORSE, M.D.; JUAN PENHOS, M.D.; WAYNE GLAZIER, M.D.; FRANCIS ROCKETT, M.D.; J. GORDON RICH, M.D.; AND JAMES BOYD, M.D.,
PETITIONERS,

v.

COMMONWEALTH OF MASSACHUSETTS, LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION,
RESPONDENTS.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS.

PETITION FOR WRIT OF CERTIORARI.

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QUESTIONS PRESENTED.

I. Does the textual and applied statutory power of a state agency retroactively to recoup medical malpractice insurance premium deficits violate Petitioners' right to procedural due process?

II. Does an unconstitutional impairment of contract occur when a subsequently enacted statute is used to substantially alter the obligation of an existing contract of insurance?

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OPINIONS BELOW.

This Petition for a Writ of Certiorari ("Petition") seeks review of a judgment of the Supreme Judicial Court of the Com-

monwealth of Massachusetts which is reported at 418 Mass. 436 (1994). A complete copy of the decision is appended to this Petition.

STATEMENT OF JURISDICTION

The opinion of the Supreme Judicial Court of Massachusetts was rendered on July 21, 1994. This Court has jurisdiction under 28 U.S.C. § 1257(3).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

United States Constitution, Fourteenth Amendment:

Section 1. *** . . . nor shall any State deprive any person of life, liberty, or property, without due process of law. . . .

United States Constitution, Article I, § 10:

No State shall . . . pass any . . . Law impairing the Obligation of Contracts. . . .

Massachusetts St. 1975, c. 362, § 6, 7th paragraph:

Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by an assessment upon the policyholders, or a rate increase applicable prospectively, or both; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term "policyholders" shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not.

Massachusetts St. 1980, c. 333.

Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by a rate increase applicable prospectively; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term "policyholders" shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not.

Massachusetts St. 1986, c. 351, § 38.

A copy of § 38 of Massachusetts St. c. 351 is appended to this Petition.

STATEMENT OF THE CASE

Prior to mid-1975, a free, albeit regulated, market for medical malpractice insurance existed in Massachusetts. Then, the Massachusetts Legislature created a Medical Malpractice Joint Underwriting Association of Massachusetts (the "JUA")[1] — an official state entity — which quickly became the only source of medical malpractice insurance for the vast majority of physicians in the Commonwealth.

The legislation provided that the JUA could, *inter alia*, "recoup" medical malpractice insurance premium "deficits" by an assessment on policyholders, or by a rate increase applicable prospectively, or both (St. 1975, c. 362, § 6, 7th paragraph).

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[1] The Medical Malpractice Joint Underwriting Association was subsequently renamed the Massachusetts Medical Professional Insurance Association.

In 1980, the Legislature modified the JUA's deficit recoupment power, restricting it only to "a rate increase applicable prospectively," the intent of that legislation being to prohibit the previously allowed retroactive assessments (St. 1980, c. 333).

In June 1986, pursuant to the power to recoup deficits purportedly granted by the 1975 statute, the Commissioner of Insurance imposed on the Commonwealth's physicians, including Petitioners, a retroactive medical malpractice insurance premium recoupment of an additional 51.9% for the period July 1, 1983 – June 30, 1984. Also in June 1986, the Commissioner imposed a retroactive premium recoupment of an additional 68.4% for the period July 1, 1984 – June 30, 1985. Both recoupments cumulatively represented *pre-existing medical malpractice insurance premium deficits* of approximately *$200,000,000*. Later that same month, the Legislature enacted yet another statute relating to medical malpractice insurance premiums, St. 1986, c. 351. *Inter alia*, this statute labeled the $200,000,000 shortfall in medical malpractice insurance premiums for the 1983 – 1984 and 1984 – 1985 periods — the "deficits" which the Commissioner had ordered "recouped" — as "deferred premium liability."[2]

Less than a year later, in April 1987, the JUA initiated an administrative proceeding before the Commissioner of Insurance, which continues even now, seeking to recoup from Petitioners and other of the Commonwealth's physicians even

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[2] *Inter alia*, that legislation labeled the $200,000,000 shortfall in medical malpractice insurance premiums — the "deficits" which the Commissioner ordered be "recouped" — as "deferred premium liability." It should be noted, however, that the $200,000,000 represented the recoupment of medical malpractice insurance premiums deficits which had *pre-existed* the Commissioner's June 6, 1986, determination that they were due, which had *pre-existed* the June 23, 1986, legislation, and which had *pre-existed* that legislation's characterization of the premium deficits to be recouped as "deferred premium liability." In other words, since an existing $200,000,000 "deficit" was being "recouped," *the legislation's "deferred premium liability"* characterization was merely a matter of nomenclature, nothing more.

more alleged medical malpractice insurance premium deficits, this time for the years *1975-1982* inclusive, and this time in the amount of approximately *$140,000,000*.

It is worth noting that the alleged insurance coverage that Petitioners and the other physicians in Massachusetts have received from the JUA beginning in 1975 has been in no real sense insurance. Their protection has been ephemeral. Normally, insurance carriers charge a current premium against their actuarialy-determined financial risk, their operating expenses, and their profit. If their projections are correct, they make money. If their calculations prove to have been wrong, they lose money. But, normally, insurance carriers cannot go back into the past and "recoup" sums that they have lost due to their mistaken actuarial calculations. That risk-taking is what the business of insurance is all about. However, because of the Massachusetts statutory provision allowing for deficit "recoupment," the JUA's underlying insurance carriers have been allowed to go back in time and obtain a correction of their underwriting mistakes and reimbursement of their underwriting losses. In other words, the carriers' underwriting mistakes have been only *temporary*, which is not the business of insurance. Even worse, the deficit recoupment power forces *the very persons who are supposed to have been insured, Petitioners and the other physicians in the Commonwealth of Massachusetts*, to make whole their supposed insurers. Because of the deficit recoupment power of the JUA, as written and as applied in a long-delayed fashion, Petitioners and the others *have been made de facto reinsurers of their own liability. They have been made sureties of their own insurance carriers' underwriting mistakes*.

In May, 1989 the Petitioners filed a complaint in the Massachusetts Superior Court challenging the constitutionality of St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, and St. 1986, c. 351. The complaint alleged that these statutes violated

the Contract Clause of the United States Constitution and the procedural due process guarantees of the United States Constitution. Both petitioners and respondents moved for summary judgment in the Massachusetts Superior Court. The Superior Court denied petitioners' motion and granted defendants' motions. The petitioners appealed and the Supreme Judicial Court of Massachusetts granted petitioners' application for direct appellate review.

The Supreme Judicial Court of the Commonwealth of Massachusetts rejected Petitioners' procedural due process and Contract Clause challenges to the constitutionality of the deficit recoupment power as written and as applied.

REASONS FOR GRANTING THE WRIT

I. PROCEDURAL DUE PROCESS

The first question presented by this Petition for a Writ of Certiorari is whether the textual and applied statutory power of a state agency retroactively to recoup medical malpractice insurance premium deficits violates the Petitioners' right to procedural due process. The question arises because Massachusetts law vested the Commissioner of Insurance with the power to go back in time and retroactively levy huge assessments against Petitioners and most other physicians in Massachusetts, and because that power has already been exercised at an actual and potential cost of hundreds of millions of dollars.

These huge costs are for physician-patient transactions which occurred in the past. There is not now, nor will there ever be, any possible way that Petitioners can recapture their portion of these sums from their *past* medical practices. Raising future fees is not an answer; they can do that quite apart from their need to be made whole as a result of the retroactive deficit recoupment premium payments. But what Petitioners cannot do

is to enter a time warp, and return to yesteryear. Petitioners cannot *now* raise their *past* fees for services rendered *then*, in an effort to retrieve expenses which only *now* they have learned from the Commissioner and the JUA that they had *then*.

In other words, Petitioners are being heavily burdened in the *present* for transactions which occurred in the *past*, and it is the importance of this issue that argues for grant of the Petition.

The case of *Railroad Retirement Board* v. *Alton*, 295 U.S. 330 (1935) is instructive in this regard. There, a federal law required interstate railroads to establish pension funds for its employees. Coverage was to include certain former railroad workers. In voiding the statute on procedural due process grounds, this Court emphasized the unconstitutionality of imposing "for the future a burden never contemplated by either party. . . . *** the provision . . . [imposes] new burdens [for] transactions long since past and closed. . . ." That is exactly what has happened to the Petitioners here.

In *Smith* v. *Illinois Bell Telephone Co.*, 270 U.S. 587 (1926), the telephone company was steadily losing money. As the law required, the company filed a proposed schedule of increased rates with the regulatory agency. Those rates, if allowed to go into effect, would have helped eliminate, or at least reduce, the ever-increasing deficits. For over three years the Illinois Commerce Commission failed to approve or disapprove the telephone company's proposed rate increases, thereby significantly worsening the company's eroding financial position. As Justice Sutherland said:

> . . . the commission for a period of two years remained practically dormant, and nothing in the circumstances suggests that it had any intention of going further with the matter. For this apparent neglect on the part of the commission, no reason or excuse has

> been given; and it is just to say that, without explanation, its conduct evinces an entire lack of that acute appreciation of justice which should characterize a tribunal charged with the delicate and important duty of regulating the rates of a public utility with fairness to its patrons, but with a hand quick to preserve it from confiscation.

Smith, supra at 590-91.

In other words, up to this point in its opinion the Court was saying, at the very least, that a state ratemaking body had an affirmative obligation, *constitutional in nature*, to prevent confiscation of the regulatee's assets (there, the telephone company's).[3]

But much more important for present purposes was what Justice Sutherland wrote for a unanimous Court, expressly concerning *the constitutionality of delay in ratemaking:*

> Property may be as effectively taken by long-continued and unreasonable delay in putting an end to confiscatory rates as by an express affirmance of them; and where, in that respect, such a state of facts is disclosed as we have here, the injured public service company is not required indefinitely to await a decision of the rate-making tribunal. . . .

Smith, supra at 591.

Thus did this Court recognize not only that a state ratemaking body had a general constitutional duty not to confiscate a regulatee's assets by setting inadequate rates, but that *delay in terminating* confiscatorily inadequate rates could also violate constitutional rights.

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[3] It is of no constitutional significance that in *Smith* the ratemaker was the Illinois Commerce Commission, and in Massachusetts it is the Commissioner of Insurance.

Admittedly, neither of these inadequate rate situations is what confronts the Petitioners here. The Commonwealth has neither *set* rates so low as to constitute confiscation due to lack of an adequate return, or through delay allowed confiscatorily inadequate rates to remain in place. Instead, the Commonwealth has done what is arguably worse: *by means of an extreme, unexplained delay it has retroactively imposed excessive rates*. In principle, there is no meaningful difference between rates which are so low as to be confiscatory, and insurance premiums which are so excessive as to be confiscatory.

Thus, the common denominator between the heart of this Court's ruling in *Smith* v. *Illinois Commerce Commission*, and what the Commonwealth of Massachusetts has done to Petitioners here, is the *delay*. In *Smith* this Court said that prejudicial ratemaking (whatever the exact nature of the harm) resulting from inordinate (there, a mere two-year) *delay*, violated constitutional rights. Manifestly, what has happened to the Petitioners here is extremely prejudicial, and it, too, has been caused by a much longer *delay*, indeed, nearly as much as two decades. Thus, the question presented by this Petition is whether, under *Alton* and *Smith*, the textual and exercised power of a state administrative agency to retroactively recoup deficit medical malpractice insurance premiums is prohibited by the same constitutional principles enunciated by this Court in those cases, particularly with regard to settled expectations (*Alton*) and excessive delay (*Smith*).

II. CONTRACT CLAUSE

The second question presented by this Petition for a Writ of Certiorari is whether an unconstitutional impairment of contract occurs when a subsequently enacted statute is used to substantially alter the obligation of an existing contract of insurance. The question arises because under the original 1975

deficit recoupment statute, the JUA was *authorized* — but not required — to recoup medical malpractice insurance premium deficits by making "assessments" on policyholders, by promulgating rate increases to be applicable prospectively, or by both. *Statutorily*, the JUA was given these choices *when obligating itself, and when dealing with and obligating Petitioners*. In the very first contract/policies that the JUA issued, it exercised that choice. In those contracts/policies, the JUA made a conscious decision *textually* to reserve to itself the power to recoup *only* by means of "*assessments*." In other words, when the JUA entered into binding contractual insurance policy agreements with Petitioners immediately following enactment of the 1975 legislation, an essential term of those contracts/policies was the *method* by which, and the *pool* from which, the JUA would collect, and Petitioners pay, deficits which might later be recouped. As the contracts/policies themselves plainly show, that method was via assessments, and *only* via assessments, and the pool from which those assessments were to be drawn was the "*policyholders*." Thus, from 1975 to 1980 both parties to the contracts/policies of insurance — the JUA and its insured physicians, Petitioners here — were contractually bound to the recoupment of deficits *only* by means of assessments on policyholders.

In 1980 the recoupment statute was amended. St. 1980, c. 333: It is important to emphasize that on the threshold of that statute's enactment, *contractually* the JUA was bound to recoup, and the physicians-insureds, Petitioners here, were bound to pay, *only* by means of assessments on policyholders. That had been the JUA's choice, for whatever reason[s]. Originally, the JUA *could* have *contractually* agreed with its physicians-insureds, with Petitioners, that the JUA retained the broad statute-authorized powers to recoup by assessments, by prospective rate increased, or by both. But the JUA failed to do so.

The 1980 amendment ended the JUA's power to recoup by means of assessments. Categorically and unequivocally, the 1980 amendment *prohibited* the JUA from recouping deficits by means of assessments. This left the JUA in the position where although it was bound *contractually* to recoup deficits only by means of assessments on policyholders, *statutorily* the power to do so had been removed. The only statutory recoupment power which remained was prospective rate increases. In light of that, following the 1980 amendment the JUA could have altered its *subsequent* (post-1980) contracts/policies to conform to what was then the *only* statutory basis for deficit recoupment, prospective rate increases. But the JUA did not.

The consequence was that as to both old (pre-1980) and new (post-1980) contracts/policies the JUA had been placed by the legislation, and had impaled itself by its contracts/policies, on the horns of a dilemma: *it had been, and continued to be, committed contractually to recoup deficits only by means of assessments on policyholders, for which there was no longer any statutory authorization*. As to the JUA's *contractual* obligation to recoup and the physicians'-insureds' *contractual* obligation to pay that recoupment solely by means of assessments, there can be no doubt. The contracts/policies are quite clear on that point. As to the impact of the 1980 amendment on the JUA's power to recoup not by means of assessments but only via prospective rate increases, there is no doubt. The statute is quite clear on that point.

Where, then, did that leave the JUA?

Notwithstanding the express "recoupment via assessments on policyholders" term of its contracts/policies, and the resultant obligation of the physicians-insureds to pay deficit recoupment only via assessment, the JUA has actually recouped, and continues to seek recoupment, by means of prospective rate increases. While these prospective rate increases may be *statutorily* authorized, they are not *contractually* authorized.

In other words — and this is the core of Petitioners' Contract Clause claim — in substituting recoupment via prospective rate increase (as authorized by the 1980 statute) for recoupment via assessments (as contractually agreed to by the JUA and its physicians-insureds), *the JUA is using, and seeking to use, a statute (the 1980 amendment) to alter the contractual term of the physicians'-insureds' contracts/policies.* Put another way, the JUA is using a state statute to *impair the mutual obligation of Petitioners' contract/policies.*

Article I, § 10, of the Constitution of the United States prohibits any state from enacting a "law impairing the obligation of contracts." While it is true that the Contract Clause fell into disuse from the New Deal era through the period of the Warren Court,[4] in recent years there has been a revival. For example, *United States Trust Co.* v. *New Jersey*, 431 U.S. 1 (1977), involved a state-issued bond containing a covenant limiting the Port Authority from subsidizing passenger rail transportation from revenues and reserves. When the covenant was repealed, a lawsuit ensued based on the Contract Clause's guarantee against impairment. In invalidating the repeal as an unacceptable impairment of the bond's obligation, this Court drew a distinction that is important for the instant case. It recognized that when state interference with a *private* contract is challenged, as in *Blaisdell*, courts generally defer to the legislative judgment as to how necessary and reasonable a particular impairment actually is, just as courts customarily defer when reviewing economic and social legislation. However, when the state is *self-interested*, as it was in *United States Trust Co.* and as it is in the instant case, and when the state impairs its *own* obligations, as it has done here, less judicial deference is warranted than when the state interferes with private contracts. Thus, in *United States Trust*, this Court

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[4] *See, e.g., Home Building & Loan Ass'n* v. *Blaisdell*, 290 U.S. 398 (1934) and *El Paso* v. *Simmons*, 379 U.S. 497 (1965).

applied a *heightened standard of review*, insisting that a law impairing a state's own obligation must be "reasonable and necessary to serve an important public purpose." Here, the JUA's explanation for why it should be able to recoup deficits by means of prospective rate increases — because it needs the money — rather than continuing to be bound by its contractual obligation to recoup only via assessments presents the question of whether the JUA's interest sufficiently satisfies the constitutional heightened review standard for impairment of a contract. Moreover, it is not only the state which has an obligation under the insurance policies. So, too, do Petitioners and the other physicians-insureds. They have an obligation to pay for the recoupment of deficits, an obligation which is *contractually* limited to payment by means of an assessment. In this regard, *Allied Structural Steel Co.* v. *Spannaus*, 438 U.S. 234 (1978) is of interest. It is not so important that *Spannaus* involved a private, as opposed to a state's own, contract, as in *United States Trust Co.* Considerably more important in *Spannaus* is that this Court held there that the statute's imposition of *a new financial obligation* on employers violated the Contract Clause. Retroactive modification of voluntarily established pension benefit obligations was both "substantial" and "severe." This Court noted that the affected company had no reason to expect that its contractual obligations would be altered, and that it had relied heavily on what it understood its obligation to be in calculating its anticipated costs. Also significant was that the legislation had not been enacted to deal with a broad, generalized economic or social problem, or enacted to protect broad societal interests or deal with desperate emergency economic conditions. Nor did the law operate merely temporarily.

The *Spannaus* analysis, buttressed by *Energy Reserves Group, Inc.* v. *Kansas Power & Light Co.*, 459 U.S. 400, 411 (1983), was reiterated by this Court not long ago. In *General*

Motors Corporation, et al. v. *Romein*, ___ U.S. ___, 112 S.Ct. 1105 (1992), Justice O'Connor wrote for a unanimous Court that in a Contract Clause analysis "[g]enerally, we first ask whether the change in state law has 'operated as a substantial impairment of a contractual relationship'. . . . This inquiry has three components: whether there is a contractual relationship, whether a change in law impairs that contractual relationship, and whether the impairment is substantial. Normally, the first two are unproblematic, and we need only address the third"[5] So, too, in the instant case. There was, and is, a contractual relationship between plaintiffs and the JUA. The statute did, and does, work an impairment of that relationship, as we stated *supra*: "In other words . . . in substituting recoupment via prospective rate increase (as authorized by the 1980 statute) for recoupment via assessments (as contractually agreed to by the JUA and its physicians-insureds), *the JUA is using, and seeking to use, a statute (the 1980 amendment) to alter the contractual term of the physicians'-insureds' contracts/policies*." Thus, the final question is whether that impairment is "substantial."

Here, when the JUA was created in 1975 Petitioners and other physicians in Massachusetts had a choice, of sorts. They could obtain medical malpractice insurance from "outside" sources, or they could sign up with the JUA, which is what most of them did. In doing so, they bargained for deficit recoupment by means of assessments "*upon the policyholders*." Since, in virtually the only definition provided by the 1975 legislation, a "policyholder" is defined as "all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not," the JUA-insured physicians bargained to be members of an identifiable, finite, pool of ratepayers who

[5] *Id.* at 1109, 1110.

collectively would be obligated to pay deficit recoupment. They did *not* bargain to be members of a potentially and/or actually different, and possibly even smaller pool of ratepayers who might exist when the JUA finally got around to levying a prospective rate increase. Yet that is the position in which they were put by the 1980 legislation, used by the JUA to impair its and Petitioners' obligations under the contracts/policies. No reasonable and necessary governmental end, calculated to serve an important public purpose (*United States Trust Co., supra*), has even been advanced to justify this impairment, let alone does one exist. As in *Spannaus, supra*, this new obligation is substantial and severe, the assessment-liable Petitioners had no reason to expect it, they relied on the explicit terms of their contracts/policies, and the JUA's use of prospective rate increases was neither emergency-based nor temporary. Whether this situation squares with the Contract Clause is a question presented by this Petition.

CONCLUSION

For the foregoing reasons, this Court should grant this Petition.

Respectfully submitted,

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October, 1994

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LIABILITY INVESTIGATIVE FUND EFFORT, INC., & others[1] *vs.* MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION & others[2] (and a companion case[3]).

Hampden. April 7, 1994. - July 21, 1994.

Present: LIACOS, C.J., ABRAMS, NOLAN, LYNCH, & GREANEY, JJ

Insurance, Medical malpractice insurance. *Statute*, Construction. *Constitutional Law*, Contracts clause, Separation of powers. *Due Process of Law*, Insurance regulation, Rate setting.

Article I, § 10, of the United States Constitution providing that "[n]o State shall . . . pass any . . . [l]aw impairing the [o]bligation of [c]ontracts," had no applicability to St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, providing for recoupment of deficits sustained by the Massachusetts Medical Professional Insurance Association by means of premium rate increases, where that statute's operation was prospective. [441-443]

Statute 1986, c. 351, enacted as a means to allow the Massachusetts Medical Professional Insurance Association to recover certain medical malpractice insurance premiums it lost as a result of a 1985-1986 rate freeze enacted by the Legislature was, as a legislative act, not subject to a procedural due process challenge; moreover, where that statute's operation affected only certain insurance policies whose premiums were expressly stated to be provisional, no considerations of due process barred retroactive redetermination of the premiums. [443-445]

Statute 1975, c. 362, § 6, as amended by St. 1980, c. 333, which provides for the recoupment of deficits sustained by the Massachusetts Medical Professional Insurance Association through premium rate increases and under which no deficit recoupment rates have yet been determined, does not violate due process by reason of the delay in its implementation inasmuch as those parties from whom recoupment may be sought did not show any confiscation or deprivation of property. [445-448]

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[1]Leonard Morse, Juan Penhos, Wayne Glazier, Francis Rockett, J. Gordon Rich, James Boyd, and E. Langdon Burwell, all of whom are physicians.

[2]Commissioner of Insurance and the Commonwealth.

[3]Robert S. Slocum *vs.* Massachusetts Medical Professional Insurance Association & others.

The provisions of St. 1986, c. 351, contain no requirement for a "plan of operation" for implementation, and this court declined to infer such a plan in interpreting the statute; accordingly a challenge to the statute for violation of the separation of powers doctrine in art. 30 of the Massachusetts Declaration of Rights, premised on such a requirement, had no merit. [448-449]

Ambiguity found in the provisions of St. 1975, c. 362, § 6, seventh par., as amended by St. 1980, c. 333, with respect to the words "then in effect," as applicable to the "plan of operation" by which deficits sustained by the Massachusetts Medical Professional Insurance Association are recouped, was properly resolved so as to effectuate the Legislature's intent and to give the statute a constitutional construction; thus, recoupment is governed by the plan of operation in effect at the time of recoupment, not at the time the deficits are accrued: accordingly, because there is now a plan of operation in effect, recoupment under that plan will not violate the separation of powers doctrine of art. 30 of the Massachusetts Declaration of Rights. [449-450]

CIVIL ACTIONS commenced in the Superior Court Department on June 2, 1988, and May 3, 1989, respectively.

The cases were heard by *Richard F. Connon*, J., on motions for summary judgment.

The Supreme Judicial Court granted a request for direct appellate review.

Henry Mark Holzer, of New York, for Liability Investigative Fund Effort, Inc., & others.

Michael J. Lacek for Massachusetts Medical Professional Insurance Association.

Eric A. Smith, Assistant Attorney General, for Commissioner of Insurance & another.

GREANEY, J. In these consolidated cases, the corporate plaintiff and the individual plaintiffs, on behalf of themselves and others similarly situated, bring constitutional challenges to two statutes relating to the provision of medical malpractice insurance by the Massachusetts Medical Professional Insurance Association (MMPIA). Both St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, and St. 1986, c. 351, provide for payments by malpractice insureds for costs incurred by the MMPIA in providing malpractice insurance in past

years. The complaints sought declaratory and other relief to challenge the statutes as violations of the contracts clause of the United States Constitution, Federal and State guarantees of procedural due process, and the separation of power requirements of art. 30 of the Declaration of Rights to the Massachusetts Constitution. Both the plaintiffs and the defendants moved for summary judgment. See Mass. R. Civ. P. 56 (a), (b), 365 Mass. 824 (1974). A judge of the Superior Court denied the plaintiffs' motion and granted the defendants' motions in a well-reasoned memorandum of decision. We granted the plaintiffs' application for direct appellate review and now affirm.

We first set forth the undisputed facts. In 1975, "to guarantee the continued availability of medical malpractice insurance" in the Commonwealth, the Legislature enacted St. 1975, c. 362, of which § 6 established the Medical Malpractice Joint Underwriting Association of Massachusetts, which is now the MMPIA. The MMPIA was authorized to issue malpractice insurance policies to physicians and hospitals that "[have] made a reasonable effort to obtain insurance and [have] been unable to obtain it." St. 1975, c. 362, § 6, fifth par. The statute stated that the MMPIA's purpose was to provide this insurance "on a self-supporting basis." St. 1975, c. 362, § 6, second par. Toward that end, both the original statute creating the MMPIA and a later statute, St. 1986, c. 351, have provided for the collection by the MMPIA of funds for past, underfunded insurance periods. It is the validity of those two statutes that the plaintiffs challenge here.

The challenged portion of St. 1975, c. 362, § 6, which we will refer to as the deficit recoupment statute, provided as follows:

> "Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by [an assessment upon the policyholders, or] a rate increase applicable prospectively [, or both]; provided, however, that in no

> event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term 'policyholders' shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through [MMPIA] or not."

St. 1975, c. 362, § 6, seventh par. This paragraph was subsequently repealed and reenacted without the bracketed language. St. 1980, c. 333. During the first dozen years of its operation, the MMPIA did not seek to recoup any deficits under this statute.

In 1987, however, the MMPIA filed a request to begin recouping deficits that accrued in the years 1975-1982. A hearing officer of the Division of Insurance, and subsequently the Commissioner of Insurance (commissioner), determined that if recoupment were ordered, it would be made from all physicians and hospitals, regardless of whether they were insured by the MMPIA. That decision was challenged and affirmed in *Risk Management Found. of Harvard Medical Insts., Inc.* v. *Commissioner of Ins.*, 407 Mass. 498, 503-505 (1990). Subsequently, on February 25, 1991, the parties to that case entered into a stipulation that no requests for recoupment would be made before April 1, 1993. To the present time, no specific determination has been made regarding the MMPIA's deficits, and no rate increase has been established.

The second statute at issue is St. 1986, c. 351, which we will refer to as the deferred premium liability statute. This statute was the eventual result of the MMPIA's recommendation of a 162.7% increase in its premium rates for its 1983 rate year. The commissioner rejected that recommendation and instead allowed only a 42% increase. The MMPIA appealed, and we determined that the commissioner had misinterpreted the applicable statutes, so we ordered further

ratemaking proceedings. *Medical Malpractice Joint Underwriting Ass'n of Mass.* v. *Commissioner of Ins.*, 395 Mass. 43 (1985). The Legislature then froze premium rates at the level of the commissioner's overturned decision. St. 1985, c. 671, § 1. It later extended the freeze to July 1, 1986. St. 1986, c. 37.

On June 6, 1986, the commissioner issued a new decision, raising the 1983 rate 93.9% above the previous year's rate, and raising the 1984 rate 10.9% above the 1983 rate. No appeal was taken from those rate decisions. Later that month the Legislature enacted the deferred premium liability statute as a means to allow the MMPIA to recover premiums it lost as a result of the legislative rate freeze. The operation of the statute was described as follows in a previous decision in this case:

> "The statute established a 'total deferred premium liability,' which is a sum representing the difference between the rates set by the commissioner pursuant to c. 175A, § 5A, for the 1983-1985 rate years and the premiums actually paid for the period pursuant to the freeze. The statute provided for recovery of the total deferred premium liability over a five-year period from July 1, 1987, through June 30, 1992, by means of a 'separate rate' added to the normal rate for policies issued during that period. The separate rates were to be assessed and recovered in the same manner as rates established pursuant to c. 175A, § 5A. See St. 1986, c. 351, § 38. The statute did not refer to the deficit recoupment provision of St. 1975, c. 362, § 6, 7th par., discussed above."

Liability Investigative Fund Effort, Inc. v. *Medical Malpractice Joint Underwriting Ass'n of Mass.*, 409 Mass. 734, 738-739 (1991).

The plaintiffs challenge the deficit recoupment statute and the deferred premium liability statute on three grounds. First, they argue that the 1980 amendment of the deficit re-

coupment statute violates the contracts clause of the United States Constitution.[4] Second, they contend that the provisions of both statutes for the recovery of funds for past policy periods violate both State and Federal guarantees of procedural due process. Third, they argue that some of the MMPIA's actions under the statutes were taken without having in place the "plan of operation" provided for by St. 1975, c. 362, § 6, and that in the absence of such a plan those actions violate the separation of powers provisions of art. 30 of the Declaration of Rights. We address each of these arguments in turn.

1. The plaintiffs' first argument is that the malpractice insurance policies issued by the MMPIA in 1975-1982, the period for which it seeks recoupment, committed it to contractual obligations that are inconsistent with St. 1980, c. 333. The specific contractual provisions on which the plaintiffs rely are exemplified by the following language in a policy endorsement from 1977: "Any deficit sustained by the [MMPIA] in any one year shall be recouped by an assessment upon all medical malpractice insurance policyholders, whether insured through the [MMPIA] or otherwise." In

[4]In their reply brief, the plaintiffs also argue that the deferred premium liability statute violates the contracts clause. This argument, however, was neither considered by the trial judge nor argued by the plaintiffs in their initial brief on appeal, where they challenged only the "prospective rate increases" of St. 1980, c. 333. We therefore need not consider this new argument here. See Mass. R. A. P. 16 (a) (2), 365 Mass. 860 (1974), and 16 (a) (4), as amended, 367 Mass. 921 (1975).

In any event, as is described below in the context of the plaintiffs' due process argument, the plaintiffs' policy agreements with the MMPIA for the years subject to deferred premium liability described the rates for those policies as "provisional." Revision of those rates is therefore not an impairment of contract. See *Weaver* v. *Graham*, 450 U.S. 24, 29-30 (1981) ("Evaluating whether a right has vested is important for claims under the Contracts or Due Process Clauses, which solely protect pre-existing entitlements"); *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 362 Mass. 34, 39-40 (1972) ("[W]e conclude that no unconstitutional . . . impairment of contract will be involved in an adjustment for excessive 1971 premiums, because the rates set for 1971 compulsory insurance were provisional and subject to change, and thus did not become the property of the companies").

light of such provisions, the plaintiffs argue, "an essential term of [the MMPIA] contracts/policies was the method by which, and the pool from which, the [MMPIA] would collect, and the insureds would pay, deficits which might later be recouped"; the contracted-for method was assessment, and the "pool" was the class of policyholders existing at the time the deficits accrued. Therefore, the argument continues, the 1980 amendment providing for recoupment only "by a rate increase applicable prospectively," and the MMPIA's proposal to recoup deficits under that amendment, are inconsistent with the MMPIA's contractual limitation to recoupment by assessment and with the commitment to recoupment from the class of policyholders existing at the time of the contracts. This, the plaintiffs say, violates art. I, § 10, of the United States Constitution, which provides that "[n]o State shall . . . pass any . . . [l]aw impairing the [o]bligation of [c]ontracts."

Resolution of the plaintiffs' claim is straightforward in light of the provision in St. 1980, c. 333, for "a rate increase applicable *prospectively*" (emphasis added). The contracts clause "applies only to laws with retrospective, not prospective, effect." *Local Div. 589, Amalgamated Transit Union* v. *Commonwealth*, 666 F.2d 618, 637 (1st Cir. 1981) (citing *Ogden* v. *Saunders*, 25 U.S. [12 Wheat.] 213 [1827]), cert. denied, 457 U.S. 1117 (1982). Hence, the clause is inapplicable here. It cannot be the case that by entering into its insurance policies the MMPIA restricted the Legislature's ability to authorize any future deficit recoupment method not specified in the policies.

The plaintiffs simply fail to distinguish between actions taken by the MMPIA under its existing contracts with policyholders and actions taken by the Legislature and the MMPIA regarding the terms of the MMPIA's future contracts. The deficit recoupment statute, St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, specifically provides that the "policyholders" subject to prospective rate increases are "all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through

[MMPIA] or not." Because the statute thus applies the rate increase to malpractice insureds regardless of whether they have had any contractual relationship with the MMPIA, it is clear that the application of that increase cannot be part of past MMPIA contracts. In fact, the plaintiffs will not themselves be subject to any eventual rate increases under the deficit recoupment statute if they are not insured under malpractice policies in Massachusetts at the time such increases are imposed. See *Risk Management Found.*, *supra* at 505 ("Recoupment liability under c. 333 is one of the many conditions of licensure which the Legislature through its police power may impose on doctors and hospitals").

2. The plaintiffs' second argument is that both St. 1975, c. 362, the deficit recoupment statute, and St. 1986, c. 351, the deferred premium liability statute, violate the procedural due process guarantees of the Federal and State Constitutions. With regard to both statutes, the plaintiffs argue that due process has been violated by "[t]he Commonwealth's undisputed delay in assessing, and in seeking to assess[,] retroactive premiums to collect these deficits."[8] Because the two statutes function differently, we will consider each separately.

We observe preliminarily that we have treated the procedural due process protections of the Massachusetts and United States Constitutions identically. See, e.g., *Allen* v. *Assessors of Granby*, 387 Mass. 117, 119 (1982); *Lotto* v. *Commonwealth*, 369 Mass. 775, 776-777 (1976). In the present case, where the plaintiffs claim that a denial of procedural due process deprived them of property, they must show first that the property interest that they claim was one to which they had an entitlement. See *Regents of State Colleges* v. *Roth*, 408 U.S. 564, 577 (1972); *Allen* v. *Assessors of Granby*, *supra* at 119. Only if the plaintiffs make such a showing do we need to consider whether the procedures used

[8]We need not resolve the parties' heated dispute over whether the effect of the deferred premium liability statute is "really" deficit recoupment. We will consider the operation of the two statutes without relying on the labels applied to them.

meet the requirements of due process. *Lotto* v. *Commonwealth*, *supra* at 777.

a. The plaintiffs' challenge to the validity of the deferred premium liability statute, St. 1986, c. 351, is subject to several responses. First, although the plaintiffs characterize their challenge as one to the delay created by the statute, it is clear that their challenge is to the Legislature's decisions themselves. The delay in assessing the premiums was expressly imposed by the Legislature in St. 1985, c. 671, and extended in St. 1986, c. 37, and collection of the delayed (deferred) premiums was expressly authorized in St. 1986, c. 351. In general, neither State nor Federal legislative acts are subject to procedural due process challenges. See *Martinez* v. *California*, 444 U.S. 277 (1980); *Bi-Metallic Inv. Co.* v. *State Bd. of Equalization*, 239 U.S. 441, 445-446 (1915). The rationale for this rule is that, regardless of whether a protected property interest is at stake, "the legislative determination provides all the process that is due." *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982). The rule applies specifically to legislative changes in benefits. *Atkins* v. *Parker*, 472 U.S. 115, 129 (1985). Such changes are subject to substantive due process challenge, *id.* ("Such a change must, of course, comply with the substantive limitations on the power of Congress . . . ."), but the plaintiffs here have stipulated to the dismissal of their counts raising such substantive challenges. Hence, their reliance on a procedural challenge is misplaced.

Moreover, the property interest that the plaintiffs claim is in insurance rates that were specifically denoted on the policies as "provisional." The deferred premium liability statute applies to "policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six." St. 1986, c. 351, § 38 (1). The policies in the record that were issued in this period all state explicitly that the rates charged in those policies are "provisional."[8]

[8]The policy issued to plaintiff Leonard J. Morse on December 13, 1983, contains the following statement: "These rates are provisional and may be

We have previously rejected a challenge to a retroactive reduction in insurance rates where those rates "were provisional and subject to change, and thus did not become the property of the [insurance] companies." *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 362 Mass. 34, 40 (1972). Although the claims rejected in that decision were only takings and impairment-of-contract claims, the same result applies more generally to the due process claims of the plaintiffs here.[7] See *Murphy Nursing Home, Inc.* v. *Rate Setting Comm'n*, 364 Mass. 454, 459 (1973) ("The Constitution of the United States interposes no barrier to retroactive redetermination of provisional or tentative rates," citing *Great N. Ry.* v. *Sunburst Oil & Ref. Co.*, 287 U.S. 358, 362 [1932]), appeal dismissed, 417 U.S. 962 (1974). The deferred premium liability statute does not violate procedural due process.

b. The deficit recoupment statute, unlike the deferred premium liability statute, does not provide expressly for the time at which the statute is to operate. Hence, with regard to the deficit recoupment statute, the plaintiffs can properly argue that "the *delay* in utilizing the existing statute is what violated due process." However, the plaintiffs cite no case that would support a procedural due process claim in these circumstances. Although they cite cases that have accepted challenges to delays, all of those cases involved deprivations of property, either through delays in ending confiscatory

adjusted when 1983 rates and class levels are published." The policies issued to Morse on December 11, 1984, and December 12, 1985, both stated that "the premiums stated in the declarations are provisional and are subject to recomputation if the rates fixed and established by the Commissioner of Insurance for use in connection with this policyare [*sic*] revised by order of the Supreme Judicial Court or the Commssioner [*sic*] of Insurance." The latter language is substantially similar to that cited in *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 362 Mass. 34, 40 (1972).

[7]The fact that the plaintiffs here are insureds, whereas in *Employers' Commercial Union* they were insurers, is also not significant. The policies provide notice of the provisional nature of the rates to both insurer and insured.

rates or delays in implementing increased benefits decisions.[8] See *Smith* v. *Illinois Bell Tel. Co.*, 270 U.S. 587, 591 (1926) ("Property may be as effectively taken by long-continued and unreasonable delay in putting an end to confiscatory rates as by an express affirmance of them"); *MCI Telecommunications Corp.* v. *FCC*, 627 F.2d 322, 341 (D.C. Cir. 1980) ("delay in the resolution of administrative proceedings can . . . deprive regulated entities, their competitors or the public of rights and economic opportunities without the due process the Constitution requires"); *Perez* v. *Lavine*, 378 F. Supp. 1390, 1394-1395 (S.D.N.Y. 1974) ("delay in the delivery of benefits" raises a substantial constitutional question); *Nelson* v. *Sugarman*, 361 F. Supp. 1132, 1134 (S.D.N.Y. 1972) (finding constitutional violation in State's "fail[ure] to implement in timely fashion fair hearing decisions which had upheld their right to increased benefits"). The plaintiffs in effect acknowledge that success of their challenge requires that there have been a deprivation of property, because they argue that, by means of the delay, the MMPIA has imposed "insurance premiums which are so excessive as to be confiscatory."[9] But the delay in deficit recoupment did not result in a confiscation of the plaintiffs' property; instead, by delaying collection, it allowed them to retain for a longer time amounts determined by statute to be due.[10] The only way in which the plaintiffs argue that they were deprived of property due to the delay is that "a sub-

[8]An exception is *Railroad Retirement Bd.* v. *Alton R.R.*, 295 U.S. 330 (1935). In that case, however, no issue of procedural due process was raised; the challenged statute was instead held to be a taking. See *id.* at 350 ("Thus the Act denies due process of law by taking the property of one and bestowing it upon another"). In the present case the plaintiffs have stipulated to the dismissal of their takings claims.

[9]The plaintiffs also argue that due process has been violated by MMPIA's imposition of the deficit recoupment rates "retroactively." However, as we concluded in the discussion of the plaintiffs' contract clause claims, the deficit recoupment statute is not retroactive.

[10]The plaintiffs do not argue in this appeal that the rates charged by the MMPIA, either originally or with the yet-to-be-determined prospective rate increases, are in themselves confiscatory; they argue only that the delay resulted in confiscation of their property.

stantial new financial obligation has been added because there is a potentially smaller ratepayer base available to pay the prospective rate increases."[11] However, they offer no evidence of the relative numbers of policyholders in 1975-1982, and the present, so this claim is purely speculative, and they have raised no genuine issue of fact. See Mass. R. Civ. P. 56 (c), 365 Mass. 824 (1974).

The plaintiffs point to one of our previous decisions, *Workers' Compensation Rating & Inspection Bureau* v. *Commissioner of Ins.*, 391 Mass. 238, 269 (1984), as support for their argument. Although that case denied the plaintiffs' claims of a violation of due process, it said that "[u]njustified delays in acting on proposed rates may in some circumstances constitute a denial of procedural due process." *Id.* at 269. However, the cases cited by the *Workers' Compensation Rating & Inspection Bureau* decision make clear that those circumstances are not present here. In one of the cases cited, *Boston Gas Co.* v. *Department of Pub. Utils.*, 368 Mass. 51 (1975), we found a violation of procedural due process where the administrative agency involved had failed to provide a hearing regarding a delay in instituting new rates. *Id.* at 54-55. In the present case, however, the plaintiffs do not challenge the process used to determine deficit recoupment rates; indeed, no deficit recoupment rates have yet been determined. Instead, they challenge the fact of the MMPIA's de-

[11]The plaintiffs do argue that, because any eventual deficit recoupment will occur after the time at which the deficits accrued, they will be unable to pass on the costs of deficit recoupment to their patients of that earlier time. However, that result is a consequence of the legislative decision to effect deficit recoupment through prospective rate increases applied to policyholders at the time of recoupment, rather than to those who were policyholders at the time the deficits accrued; it would be the case regardless of the delay in deficit recoupment.

The plaintiffs also claim that the very existence of deficit recoupment, which requires policyholders collectively to eventually pay all the costs of their malpractice claims, means that they were deprived of an interest "in purchasing real insurance and in getting the value of what they have bought." Insurance, however, involves not just the shifting of risk from insured to insurer, but also risk-sharing among insureds. The fact that the MMPIA will not suffer losses does not deprive the plaintiffs of insurance.

lay in seeking the deficit recoupment. Such a challenge is not supported by *Boston Gas*, which mentioned a constitutional problem as the result of delay itself only where "there has been confiscation of . . . property as a result of agency action." *Id.* at 54.[12] Here, as described above, the plaintiffs have shown no confiscation, and have therefore shown no violation of due process.

3. The plaintiffs' final claim is that the MMPIA has not complied with the requirements in St. 1975, c. 362, § 6, that the MMPIA have in place a "plan of operation." The plaintiffs point to the statute's direction that "[t]he commissioner shall, after consultation with the [MMPIA] . . . and other affected individuals and organizations promulgate a plan of operation," St. 1975, c. 362, § 6, fourth par., and to the following portion of the deficit recoupment statute:

> "Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by a rate increase applicable prospectively . . . ."

St. 1975, c. 362, § 6, seventh par., as amended by St. 1980, c. 333. It is undisputed that the commissioner promulgated a plan of operation effective June 27, 1975, but that the plan terminated by its own terms on December 31, 1977. A new plan was promulgated on June 15, 1991.

The plaintiffs therefore allege that there was no plan of operation in place between January 1, 1978, and June 15, 1991. They argue that any actions taken by the MMPIA in the absence of such a plan are invalid as a violation of the doctrine of separation of powers in art. 30 of the Declaration

[12]The other two cases cited by the *Workers' Compensation Rating & Inspection Bureau* decision are to the same effect. *Warner Cable of Mass., Inc.* v. *Community Antenna Television Comm'n*, 372 Mass. 495 (1977), relies on *Boston Gas Co.* v. *Department of Pub. Utils.*, 368 Mass. 51 (1975), and *Smith* v. *Illinois Bell Tel. Co.*, 270 U.S. 587 (1926), is discussed above.

of Rights.[13] As with their procedural due process claim, the plaintiffs argue that the absence of a plan of operation invalidates actions taken under both the deferred premium liability and deficit recoupment statutes, and we discuss each statute separately.

a. The plaintiffs do not argue that the deferred premium liability statute, St. 1986, c. 351, itself requires a plan of operation. They argue instead that a plan of operation is necessary because "deferred premium liability is merely deficit recoupment under a different name," and that it therefore requires a plan of operation as provided in the deficit recoupment statute. However, regardless of what deferred premium liability really "is," we must interpret the deferred premium liability statute as it is written. The plaintiffs point to no reference to a "plan of operation" in St. 1986, c. 351, or in either St. 1985, c. 671, or St. 1986, c. 37, the two statutes that imposed the deferral of the eventual rate increases. On the contrary, St. 1986, c. 351, itself provides in detail the terms for the recovery of deferred premium liability. The statute directs the commissioner to calculate "separate rates" to be collected in equal amounts in the four rate years from July 1, 1987, to June 30, 1991, and states that the separate rates "may be assessed and recovered with respect to policies of medical malpractice insurance issued during said periods by the [MMPIA] in the same manner as rates established pursuant to [G. L. c. 175A, § 5A] are assessed and recovered." St. 1986, c. 351, § 38 (3). These provisions describe the means for collecting deferred premiums, they impose no requirement of a plan of operation, and we will not infer one.

[13]Article 30 provides:

> "In the government of this commonwealth, the legislative department shall never exercise the executive and judicial powers, or either of them: the executive shall never exercise the legislative and judicial powers, or either of them: the judicial shall never exercise the legislative and executive powers, or either of them: to the end it may be a government of laws and not of men."

b. As described above, the deficit recoupment statute provides in relevant part:

> "Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan *then in effect* by a rate increase applicable prospectively . . . " (emphasis added).

St. 1975, c. 362, § 6, seventh par., as amended by St. 1980, c. 333. The plaintiffs argue that the emphasized language requires that the MMPIA recoup deficits by applying the plan of operation in effect at the time the deficits accrued. The judge, however, "decline[d] to read the language in that manner and conclude[d] that another reasonable interpretation of the statute would read this same language as requiring the [MMPIA] to employ the plan in effect at the time of recoupment." Although we recognize that the statute as written is ambiguous, we think that the judge's interpretation is the more sensible.

As described above, the operation of the deficit recoupment statute is purely prospective, so it would be anachronistic for the terms of that recoupment to be governed by past plans of operation. Recoupment will be made from those who are medical malpractice policyholders at the time of the recoupment, not at the time the deficits are accrued, as described above, and it would be unreasonable to require the MMPIA, and policyholders, to refer to past plans of operation to determine the method of recoupment. Moreover, such an interpretation would introduce needless complication if the plans for past years differed and, as here, deficits were to be recouped for several different years. We conclude that the better reading of the statute is that deficit recoupment is to be governed by the plan of operation in place at the time of the recoupment. This construction effectuates the Legislature's intent, see *James J. Welch & Co.* v. *Deputy Comm'r of Capital Planning & Operations*, 387 Mass. 662, 666 (1982), and gives the statute a constitutional construction, see *Ferguson* v. *Commissioner of Corps. & Taxation*, 316

Mass. 318, 322-324 (1944). Because there is now a plan of operation in effect, recoupment under that plan will not violate the separation of powers provision of art. 30.

4. In sum, neither the deficit recoupment statute, St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, nor the deferred premium liability statute, St. 1986, c. 351, violates the contracts clause of the United States Constitution, State or Federal guarantees of procedural due process, or the separation of powers requirements of art. 30 of the Declaration of Rights. The amended summary judgment and the amended partial summary judgment, both entered on July 30, 1993, are affirmed.

So ordered.

SECTION 36. Said section 6 of said chapter 362 is hereby further amended by adding the following paragraph:-

Effective January first, nineteen hundred and eighty-seven, the commissioner is authorized to establish a system of surcharges and credits for all physicians insured by the association. Said system shall provide for surcharges to be imposed on all physicians insured by the association whose claims in the previous five years exceed in number the average number of claims asserted against physicians in their specialty. Such surcharges each year for a physician shall be calculated on an actuarially sound basis to reflect the increased cost of defending physicians with more claims asserted against them than the average in their specialty. A physician who does not renew his policy with the association for any year will not be liable for any surcharges for the year of nonrenewal, except that a physician who would otherwise be liable for a surcharge and purchases from the association coverage for occurrences which took place during a period in which he was covered under a claims-made policy may be charged in the premium for such additional coverage a surcharge calculated on an actuarially sound basis. Said system shall further provide for credits to be given to all physicians insured by the association who have not had a civil action commenced against them for malpractice, error or mistake in the provision or failure to provide medical or surgical services during their practice in the commonwealth over a time period which the commissioner by regulation shall determine. The credit or credits will be calculated by specialty on an actuarially sound basis to reflect any decreased likelihood of such physicians incurring liability for claims for which the association will be liable.

SECTION 37. Said chapter 362 is hereby further amended by striking out section 13, as most recently amended by chapter 650 of the acts of 1985, and inserting in place thereof the following section:-

Section 13. Sections four, six and twelve of this act shall take effect upon their passage, and all other sections of this act shall take effect on January first, nineteen hundred and seventy-six. Section six of this act shall terminate on July first, nineteen hundred and ninety-two.

SECTION 38. (1) As used in this section, the following terms shall have the following meanings:-

"Total deferred premium liability", an amount equal to the difference between the amount of premium charges payable with respect to all policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for medical malpractice insurance for physicians in the commonwealth insured by the medical malpractice joint underwriting association, created pursuant to section six of chapter three hundred and sixty-two of the acts of nineteen hundred and seventy-five, as finally established with respect to such policies pursuant to the provisions of section five A of chapter one hundred and seventy-five A of the General Laws, and the amount of premium charges which were payable with respect to such policies during said period, as established by the commissioner of insurance in his decision dated May eighteenth, nineteen hundred and eighty-four.

"Individual deferred premium liability", an amount equal to the difference between the amount of premium charges payable with respect to policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for medical malpractice insurance for an individual physician in the commonwealth insured by the medical malpractice joint underwriting association, as finally established with respect to such policies pursuant to the provisions of section five A of chapter one hundred and seventy-five A of the General Laws, and the amount of premium charges which were payable with respect to such policies during said period, as established by the commissioner of insurance in his decision dated May eighteenth, nineteen hundred and eighty-four.

(2) Notwithstanding any general or special law to the contrary, with respect to policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for medical malpractice insurance for physicians in the commonwealth insured by the medical malpractice joint underwriting association, no premium charges shall be recovered, except as provided in paragraph (4) of this section, prior to July first, nineteen hundred and eighty-seven in excess of the premium charges established by the commissioner of insurance in his decision dated May eighteenth, nineteen hundred and eighty-four. Nothing contained in this section shall be construed to prevent or interfere with the final establishment of premium charges with respect to such policies by the commissioner of insurance pursuant to the provisions of section five A of chapter one hundred and seventy-five A of the General Laws, provided that the total deferred premium liability or any individual deferred premium liability accruing with respect to such policies shall be recovered only in accordance with the provisions of paragraphs (3) and (4), respectively, of this section.

(3) Commencing on July first, nineteen hundred and eighty-seven, the total deferred premium liability shall be recovered by the joint underwriting association as follows. The commissioner of insurance shall annually determine the portion of the total deferred premium liability then outstanding which is attributable to each risk classification of premium charges for policies of medical malpractice insurance. In making such determinations, the commissioner shall attribute to each such classification that portion of the total deferred premium liability then outstanding which accrued with respect to policies of medical malpractice insurance issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for physicians engaging in the practice or specialty included in such classification as of the date of such determination. In making such determination, the commissioner shall also deduct from the portion of the total deferred premium liability then outstanding which would otherwise be attributable to each such classification any amounts of individual deferred premium liability which have been recovered pursuant to paragraph (4) of this section. With respect to policies of medical malpractice insurance issued by the joint underwriting association on or after July first, nineteen hundred and eighty-seven and before July first, nineteen hundred and ninety-two, the commissioner

shall, in addition to the rates established for such policies pursuant to section five A of chapter one hundred and seventy-five A of the General Laws, establish a separate rate for each risk classification which shall be sufficient to permit the recovery by the association of the following amounts, plus interest on the amount then outstanding calculated at the rate of eleven per cent per year, commencing as of July first, nineteen hundred and eighty-seven: twenty per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and eighty-seven for each such classification, such rate to apply to policies issued on or after July first, nineteen hundred and eighty-seven and before July first, nineteen hundred and eighty-eight; twenty-five per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and eighty-eight for each such classification, such rate to apply to policies issued on or after July first, nineteen hundred and eighty-eight and before July first, nineteen hundred and eighty-nine; thirty-three and one-third per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and eighty-nine, such rate to apply to policies issued on or after July first, nineteen hundred and eighty-nine and before July first, nineteen hundred and ninety; fifty per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and ninety, such rate to apply to policies issued on or after July first, nineteen hundred and ninety and before July first, nineteen hundred and ninety-one; and one hundred per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and ninety-one, such rate to apply to policies issued on or after July first, nineteen hundred and ninety-one and before July first, nineteen hundred and ninety-two. Such separate rates may be assessed and recovered with respect to policies of medical malpractice insurance issued during said periods by the Joint Underwriting Association in the same manner as rates established pursuant to section five A of chapter one hundred and seventy-five A of the General Laws are assessed and recovered.

(4) Notwithstanding the provisions of paragraph (2) of this section, any physician who was covered by a policy of medical malpractice insurance issued by the Joint Underwriting Association on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six and who ceases to practice medicine in the commonwealth, unless such cessation is caused by the death of the physician, the retirement of the physician due to disability or after attainment of age sixty-five, or the relocation of the physician outside of the commonwealth immediately upon completion of a residency or internship, shall be liable as of the date of such cessation of practice for the amount of individual deferred premium liability which has accrued with respect to such policies; provided that if such cessation of practice occurs after July first, nineteen hundred and eighty-seven, said individual deferred premium liability shall be reduced by the amount of total deferred premium liability recovered from said physician pursuant to paragraph (3) of this section. The joint underwriting association shall report to the commissioner of insurance no later than April first of each year, commencing in nineteen hundred and eighty-seven and

until nineteen hundred and ninety-one, of the amounts recovered from physicians in each risk classification who are subject to recovery of individual deferred premium liability pursuant to this paragraph. Failure by the association to report any amount recovered from a physician pursuant to this paragraph shall constitute an unfair and deceptive insurance act punishable under chapter one hundred and seventy-six D of the General Laws; provided that each such failure to report shall constitute a separate act or practice for the purpose of imposition of penalty under that chapter.

SECTION 39. The special commission on medical malpractice established in chapter three hundred and sixty-two of the acts of nineteen hundred and seventy-five is hereby authorized and directed to conduct an investigation and study of the legal, tax, reimbursement, and regulatory status of nonprofit hospital service corporations and nonprofit medical service corporations, as established pursuant to chapters one hundred and seventy-six A and one hundred and seventy-six B of the General Laws. Said study shall also include a review of the standing of said corporations in relationship to other health care insurers and nonprofit medical service corporations within and without the commonwealth, to government programs of health insurance and to competing and alternative forms of health care financing. Particular attention shall be paid to the corporations' rights to contract with professional and other noninstitutional providers of health care services, the system of payments made by said corporation, including the impact of the prohibition on the practice of balance billing, so-called, the process by which the fees paid by said corporations to participating physicians are set, the extent to which said fees are reflective of the costs of providing medical services, including but not limited to, the cost of medical malpractice premiums, the adequacy and efficacy of existing dispute resolution mechanisms available to said corporations and professional providers, the financial and accounting procedures of said corporations and their impact on the quality and cost of health care services.

Said commission is further directed to conduct an investigation and study into the feasibility of establishing a patient compensation fund, so-called. Said study shall include a review of the operation of such funds in other states, an analysis of various funding mechanisms, and an estimate of the administrative cost of such a fund and its potential impact on medical malpractice premiums.

Said commission is further directed to conduct an investigation and study relative to the viability of a system which would provide for early tender of compensation to victims of medical malpractice, the economic ramifications of such a system upon such victims, the potential effect such a system might have upon premiums for medical malpractice insurance, the ability of the joint underwriting association to administer a system of early tender of compensation, a comparison of an early tender system of compensation to the existing medical malpractice procedure, the question of whether or not a system of early tender of compensation would have a negative effect on the ability of this commonwealth to effectively oversee and, where necessary, to discipline

No. 94-725

Supreme Court, U.S.
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IN THE
Supreme Court of the United States
October Term, 1994

LIABILITY INVESTIGATIVE FUND EFFORT, INC.; LEONARD MORSE, M.D.; JUAN PENHOS, M.D.; WAYNE GLAZIER, M.D.; FRANCIS ROCKETT, M.D.; J. GORDON RICH, M.D.; AND JAMES BOYD, M.D.,
Petitioners,

v.

COMMONWEALTH OF MASSACHUSETTS, LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS.

BRIEF OF THE MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION IN OPPOSITION TO THE PETITION FOR WRIT OF CERTIORARI.

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November 17, 1994

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QUESTIONS PRESENTED

I. PROCEDURAL DUE PROCESS CLAIMS

A. *Deferred Premium Liability*

1. Did the Supreme Judicial Court of Massachusetts err in determining that the decision of the Massachusetts Legislature to delay the collection of certain medical malpractice rate increases embodied in Section 38 of Chapter 351 of the Massachusetts Acts of 1986 did not violate the petitioners' procedural due process rights?

2. Did the Supreme Judicial Court of Massachusetts err in determining that the petitioners did not have a protectible property interest in expressly provisional medical malpractice insurance rates?

B. *Deficit Recoupment*

1. Did the Supreme Judicial Court of Massachusetts err in determining the petitioners have no procedural due process claims under a deficit recoupment statute which had not been, and may never be, applied?

II. CONTRACTS CLAUSE CLAIM

A. *Deficit Recoupment*

1. Did the Supreme Judicial Court of Massachusetts err in determining that Chapter 333 of the Massachusetts Acts of 1980, which made prospective rate increases the sole means by which deficits of the Medical Malpractice Joint Underwriting Association (now "MMPIA") could be recouped, did not impair the obligations of any contract entered into prior to its enactment?

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October Term, 1994

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Petitioners,

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COMMONWEALTH OF MASSACHUSETTS, LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION,

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ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS.

BRIEF OF THE MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION IN OPPOSITION TO THE PETITION FOR WRIT OF CERTIORARI.

The respondent, the Massachusetts Medical Professional Insurance Association ("MMPIA"),[1] respectfully requests that

[1] The MMPIA was previously known as the Medical Malpractice Joint Underwriting Association of Massachusetts or the "JUA." In order to avoid confusion, this brief will refer to the association by its current acronym, as did the decision of the Supreme Judicial Court.

this Court deny the Petition for Writ of Certiorari, seeking review of the decision of the Supreme Judicial Court of Massachusetts in this case. That decision is reported at 636 N.E.2d 1317 (Mass. 1994), and reprinted in the appendix to the Petition.

CONSTITUTIONAL AND STATUTORY PROVISIONS.

In addition to the statutes and constitutional provisions set forth in the Petition, the MMPIA relies on Massachusetts General Laws, Chapter 175A, § 5A, Chapter 351 of the Massachusetts Acts of 1986, §§ 2, 15, 17, and 18, and Massachusetts Senate Bill No. 1596. Copies of these statutes and the proposed legislation are reprinted in the appendix hereto. (A1-A23).

STATEMENT OF THE CASE.

As has been true throughout this litigation, the petitioners generally ignore the undisputed facts that underlie this case and were relied upon by the Supreme Judicial Court, in a transparent attempt to manufacture issues of constitutional significance that were not decided, and did not need to be decided, by that court. In their Statement of the Case, the petitioners do not challenge the facts that the Supreme Judicial Court found to be controlling. Nor do they assert that there are additional facts that the Supreme Judicial Court neglected to consider that would compel a different conclusion on the legal issues that they seek to resurrect. Instead, the Petition poses a variety of abstract constitutional issues that are not raised or supported by the factual record below.

Rather than burden this Court with a point-by-point recitation of the inaccuracies and omissions in the petitioners' "Statement

of the Case," however, this brief generally will rely upon the concise statement of undisputed facts set forth in the Supreme Judicial Court's opinion.[2] (Pet. A2-A5). As is demonstrated in the argument that follows, when these undisputed facts are considered, the correctness of the Supreme Judicial Court's decision in denying the petitioners' constitutional claims is so obvious that it is understandable why the petitioners essentially ignored that decision in seeking relief from this Court. There are, moreover, several facts not addressed in the Supreme Judicial Court's decision that further compel the conclusion that this case presents no issue worthy of this Court's consideration.

This case involves a challenge to two Massachusetts statutes.[3] The first is the enabling legislation that established the MMPIA and provided for the recoupment of deficits incurred by it. St. 1975, c. 362, § 6, (the "Enabling Act") *as amended by* St. 1980, c. 333. (Pet. 2-3). Although several other states also established medical malpractice joint underwriting associations during the medical malpractice insurance crisis of the mid-1970's, the specific statutory mechanism for the recoupment of deficits at issue here is unique to Massachusetts. So too are the 1980 amendment to that statute and the terms and conditions of the insurance policies issued by the MMPIA prior to that amendment, which form the factual foundation for the petitioners' Contracts Clause claims.

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[2] To the extent that a more detailed historical background of the Massachusetts statutes at issue here would be helpful, the earlier decisions of the Supreme Judicial Court in *Risk Management Foundation of Harvard Med. Institutions, Inc.* v. *Commissioner of Ins.*, 554 N.E.2d 843 (Mass. 1990) and *Liability Investigative Fund Effort, Inc.* v. *Medical Malpractice Joint Underwriting Ass'n*, 569 N.E.2d 797 (Mass. 1991) are instructive.

[3] One of the more persistently frustrating factual mischaracterizations engaged in by the petitioners is their insistence that these two statutes are "really" one in the same, *see*, Petition, (p. 4, n.2), when it is perfectly clear that they are not. *See* decision below (Pet. A8, n.5).

Moreover, as the Supreme Judicial Court noted, although the MMPIA initiated a request for a prospective rate increase to recoup deficits in 1987, no such rate increase has ever been established, much less assessed against the petitioners. (Pet. A4, A12). In fact, the financial position of the MMPIA has now improved to the point that it no longer needs to recoup any deficits and would have dismissed the pending administrative proceedings, but for the refusal of another party to that proceeding to agree to a dismissal during the pendency of this lawsuit. In any event, the MMPIA is not actively pursuing deficit recoupment and has sponsored legislation to convert the MMPIA into a mutual company that would not have any authority to recoup deficits. *See* Massachusetts Senate Bill No. 1596, A17-A23. Thus, the petitioners' challenge to the deficit recoupment statute asserts injuries that have never occurred and are not likely to occur.

The second statute challenge by the petitioners, the so-called "deferred premium liability" statute, St. 1986, c. 351, § 38, (Pet. 3, A17-A20), was also enacted to address circumstances unique to Massachusetts medical malpractice ratemaking. In substance, that statute permitted the deferred collection of medical malpractice rate increases for the 1983, 1984, and 1985 policy years. Those rate increases arose out of a successful appeal to the Supreme Judicial Court, decided in 1985, that overturned the Commissioner's initial decision establishing the rates for the 1983 policy year. *Medical Malpractice Joint Underwriting Association of Mass.* v. *Commissioner of Ins.*, 478 N.E.2d 936 (Mass. 1985).[4] The collection of the increases for 1983 and

[4]The medical malpractice ratemaking statute, Massachusetts General Laws chapter 175A, § 5A, provides in pertinent part: "Any person or company aggrieved by any action, order, finding or decision of the commissioner under this section may, within twenty days from the filing of such memorandum thereof in his office, file a complaint in the supreme judicial court for the county of Suffolk for a review of such action, order, finding or decizion." (A4). The 1983 rates were reviewed under this statute, and the Commissioner was ordered by the court to correct various aspects of his decision and to set the 1983 rates accordingly.

the establishment of the rates for 1984 and 1985 were delayed when the Legislature temporarily froze the premiums that could be charged by the MMPIA at the level of the provisional 1983 rates overturned by the Supreme Judicial Court's 1985 decision. St. 1985, c. 671 *as amended by* St. 1986, c. 37. The 1986 deferred premium liability statute authorized the MMPIA to collect these rate increases, as well as the increase for 1985, over a five-year period commencing in 1987, in order to avoid the undue economic burden of a one-time charge upon the affected physicians. St. 1986, c. § 38. (Pet. A17-A20). That same statute required that the fees paid to physicians by medical service corporations (*e.g.* Blue Cross/Blue Shield of Massachusetts) and by governmental and workers' compensation payors be increased to compensate physicians for these increases in medical malpractice insurance rates. St. 1986, c. 351, §§ 2, 18. (A7, A10-A16). *See Massachusetts Medical Society* v. *Commissioner of Ins.*, 520 N.E.2d 1288, 1297-98 (Mass. 1988). The last of the deferred premium liability was billed and collected more than three years ago.[5] During the period that the MMPIA collected the deferred premium liability, physicians also received the increased fees required by Sections

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Medical Malpractice Joint Underwriting Association v. *Commissioner of Ins.*, 478 N.E.2d 936 (Mass. 1985). Subsequent decisions of the Supreme Judicial Court addressing the deferred premium liability include *Massachusetts Medical Society* v. *Commissioner of Ins.*, 520 N.E.2d 1288, 1291-92 (Mass. 1988); *Massachusetts Medical Society* v. *Commissioner of Ins.*, 537 N.E.2d 797 (Mass. 1989); and an earlier decision in this case, *Liability Investigative Fund Effort, Inc.* v. *Medical Malpractice Joint Underwriting, Ass'n.*, 569 N.E.2d 797 (Mass 1991). The Supreme Judicial Court also has previously addressed issues arising out of the administrative proceeding concerning deficit recoupment in *Risk Management Foundation of Harvard Med. Institutions, Inc.* v. *Commissioner of Ins.*, 554 N.E.2d 843 (Mass. 1990).

[5] The MMPIA did not collect the fifth and final year of deferred premium liability, because more mature ratemaking data which became available in 1989 and 1990 indicated that the additional premium would not be necessary to cover the actuarially determined losses and expenses for the deferred premium liability rate years.

2 and 18 of the statute to compensate them for the increased malpractice rates.

Furthermore, to avoid the delays that occurred in implementing the 1983, 1984, and 1985 rate increases, the Legislature also amended the ratemaking statute applicable to medical malpractice rates. Those amendments provided (a) that rate requests by the MMPIA be filed more than a year in advance of their effective date; (b) that the decision of the Commissioner with respect to such filings be made at least four months prior to the effective date of the rates; and (c) that interim rates equal to the rates recommended by one of the parties to the hearing be charged in the event that the rates are not finally fixed in accordance with the statutory schedule. Mass. G.L. c. 175A, § 5A, *as amended by* St. 1986, c. 351, §§ 15 and 17. (A1-A6, A8-A10). Thus, the deferred premium liability statute was a legislative response to unique factual circumstances that were limited to Massachusetts medical malpractice ratemaking during the specific years in question and that will not reoccur under the revised statutory system.

REASONS WHY THE PETITION SHOULD BE DENIED.

Because the issues in this case involve unique factual circumstances peculiar to Massachusetts medical malpractice ratemaking and, consequently, will not arise again even in Massachusetts, a decision by this Court would be of purely academic interest, if any, to anyone other than the parties involved. Accordingly, the petitioners have not shown and cannot establish that the issues raised in this case are of sufficient public importance to warrant consideration by this Court. As this Court has stated:

> A federal question raised by a petitioner may be of "substance" in the sense that, abstractly considered, it may present an intellectually interesting and solid problem. But this Court does not sit to satisfy a scholarly interest in such issues. Nor does it sit for the benefit of the particular litigants . . . "Special and important reasons" imply a reach to a problem beyond the academic or the episodic.

Rice v. *City Cemetery*, 349 U.S. 70, 74 (1955). (Citations omitted).

The Supreme Judicial Court was thoroughly familiar with both the statutes governing the establishment of medical malpractice insurance rates for the MMPIA and the complex legislative and procedural history that underlies the issues in the case. *See* n.4 *supra* (referring to the five Supreme Judicial Court decisions that underlie the present decision). When that history is considered, it is clear that the Supreme Judicial Court correctly identified and decided the limited constitutional issues that the petitioners were entitled to raise. Consequently, there is no issue that warrants further review by this Court.

I. PROCEDURAL DUE PROCESS.

The procedural due process issue framed by the petitioners treats the two statutes they challenge as though they were identical by asking "whether the textual and applied statutory power of a state agency retroactively to recoup medical malpractice insurance premiums violates the petitioners' right to procedural due process." (Pet. 6). As noted above, however, the two statutes the petitioners are challenging function differently and, as the Supreme Judicial Court recognized, must

be analyzed separately. (Pet. A4, A8). After evaluating the petitioners' claims with respect to each statute, the Supreme Judicial Court correctly ruled that neither St. 1986, c. 351, the deferred premium liability statute (Pet. A17-A20), nor St. 1975, c. 362, § 6, *as amended by* St. 1980, c. 333, the deficit recoupment statute (Pet. 2-3), violated the petitioners' procedural due process guarantees in the Massachusetts or United States Constitutions. (Pet. A8-A13).

A. *The Supreme Judicial Court Correctly Ruled That The Deferred Premium Liability Statute Did Not Violate Petitioners' Due Process Rights.*

1. The decisions of the Massachusetts Legislature are not subject to procedural due process challenges.

The Supreme Judicial Court correctly rejected the petitioners' arguments that delay in collecting rate increases imposed by the deferred premium statute violated their procedural due process rights. St. 1986, c. 351. (Pet. A17-A20). The 1986 Deferred Premium Liability Statute permitted the MMPIA to collect the difference between (1) the provisional malpractice premium rates billed to physicians and hospitals for the 1983, 1984 and 1985 rate years and (2) the final, higher rates approved after a successful appeal and a remand to the Insurance Commissioner. The provisional rates that were billed were established by a decision of the Commissioner issued on May 18, 1984, which was later overturned by the Supreme Judicial Court in *Medical Malpractice Joint Underwriting Association* v. *Commissioner of Ins.*, 478 N.E.2d 936 (Mass. 1985). The Legislature subsequently froze the premium rates for policies issued on or after July 1, 1984 at the rates initially established by the Commissioner on May 18, 1984. *See* St. 1985, c. 671, § 1, *as amended* by St. 1986, c. 37.

After the Commissioner of Insurance established revised premium rates for the 1983 and 1984 policy years in his decision on remand from the Supreme Judicial Court, the Legislature passed the deferred premium statute in 1986. That statute allowed the MMPIA to collect the difference between the provisional premiums already received and the new higher rates but required that the collection be deferred and collected over five years. St. 1986, c. 351, § 38. (Pet. 3, A17-A20). As the Supreme Judicial Court held, the delay in establishing and collecting the premium increases challenged by the petitioners was expressly imposed by the Legislature in these statutes. (Pet. A9). Consistent with the decisions of this Court, the Supreme Judicial Court reasoned that the petitioners could not maintain a *procedural* due process challenge to these legislative decisions. (Pet. A9, citing *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982) (legislative process itself affords "all the process that is due")) *See also Atkins* v. *Parker*, 472 U.S. 115, 127-130 (1985) (no right to individual notice of statutory changes in benefits); *Bi-Metallic Inv. Co.* v. *State Bd. of Equalization*, 239 U.S. 441, 445-446 (1915) (state legislative acts are not generally subject to procedural due process challenges).

2. The petitioners do not have a protectible property interest in provisional insurance rates.

As a second ground for denying the petitioners' due process challenge to the deferred premium liability statute, the Supreme Judicial Court properly concluded that the petitioners had no legitimate property interest in the provisional malpractice premiums they were originally charged. (Pet. A9-A10). The Supreme Judicial Court found that each of the policies issued in the years governed by St. 1986, c. 351 declared on its face

that the malpractice premium rates being charged were provisional. (Pet. A9). The court concluded that because the original rates were expressly subject to change once the final rates were established, the petitioners did not have a protected property interest in the original rates. (Pet. A10).

The Supreme Judicial Court's conclusion that petitioners have no legitimate property interest in expressly provisional insurance rates is consistent with the standard established by this Court in *Board of Regents* v. *Roth*, 408 U.S. 564 (1972). For petitioners to demonstrate that they have a property interest in preserving the malpractice premiums they were originally charged:

> [They] must have more than an abstract need or desire for it. [They] must have more than a unilateral expectation of it. [They] must, instead, have a legitimate claim of entitlement to it.

Id. at 577.

The petitioners were on notice from the time the MMPIA was established in 1975 that the rates established by the Commissioner were subject to review by the Supreme Judicial Court. (A3-A4). Thus, the petitioners had statutory notice and, through the declarations on the face of the policy, actual notice that the rates were subject to change. When such expressly provisional rates are later revised, procedural due process is not violated. *Great N. Ry.* v. *Sunburst Oil and Ref. Co.*, 287 U.S. 358, 361-362 (1932) (commission's decision to change provisional shipping rates did not violate right of procedural due process).

Accordingly, consistent with the principles enunciated by this Court and with its own decisions, the Supreme Judicial Court properly determined that the petitioners had no protec-

tible property interest in the provisional rates the MMPIA charged in 1983, 1984 and 1985. *See Murphy Nursing Home, Inc.* v. *Rate Setting Comm'n*, 305 N.E.2d 837, 841 (Mass. 1973) *appeal dismissed*, 417 U.S. 962 (1974), ("[t]he Constitution of the United States interposes no barrier to retroactive redetermination of provisional or tentative rates"); *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 283 N.E.2d 849, 853 (Mass. 1972) (because insurance rates were expressly subject to change, they did not constitute property). For all of these reasons, the Supreme Judicial Court correctly concluded that the deferred premium liability statute did not violate the petitioners' due process rights.

B. *The Supreme Judicial Court Correctly Held That The Deficit Recoupment Statute Has Not Operated to Deprive Petitioners of Any Property And, Therefore, Does Not Violate Their Right to Procedural Due Process.*

There is a fundamental flaw in petitioners' argument that the "textual and applied statutory power" that allows the MMPIA to recoup deficits violates petitioners' procedural due process rights (Pet. 6-7): the petitioners have never been required to pay any additional malpractice premiums pursuant to the deficit recoupment statute. Thus they have never been *deprived* of any property within the meaning of the Fourteenth Amendment. *See Board of Regents* v. *Roth, supra*, 408 U.S. at 569 ("The requirements of procedural due process apply only to the deprivation of interests encompassed by the Fourteenth Amendment's protection of liberty and property.").

The petitioners attempt to obfuscate their failure to meet this prerequisite by mischaracterizing the deferred premium liability rate increase as an exercise of the deficit recoupment power. (Pet. 4). The Supreme Judicial Court properly disre-

garded this transparent sleight of hand designed to create a constitutional issue and held, based upon the undisputed facts in the record, that the Commissioner of Insurance has not ordered any recoupment nor established any rate increase since the MMPIA filed is request in 1987 to recoup deficits for the years 1975 through 1982. (Pet. A4, A12). That finding would not be disturbed, even if this Court were to grant certiorari in this case. *Fry Roofing Co.* v. *Wood*, 344 U.S. 157, 159-60 (1952) (state court findings are not subject to review if there is any evidence in the record to support them). As the Supreme Judicial Court properly determined, that finding renders entirely inapposite *Smith* v. *Illinois Bell Tel. Co.*, 270 U.S. 587, 591 (1926), and related cases holding that delay in acting upon a requested rate increase may result in confiscation of property in violation of the requesting company's right to procedural due process. (Pet. A11).[6] The petitioners' contention that their constitutional rights have been harmed by something that has not yet happened does not merit the attention of this Court.[7]

Moreover, even if a prospective rate increase had been established and assessed pursuant to the deficit recoupment statute, for much the same reasons already discussed in connection with the deferred premium liability statute, the petitioners would be

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[6] The petitioners' citation of this Court's decision in *Railroad Retirement Bd.* v. *Alton R.R.*, 295 U.S. 330 (1935) suggests that they may be attempting to articulate a substantive due process claim. As the Supreme Judicial Court noted, however, the petitioners had stipulated to the dismissal of their takings claims prior to its decision. (Pet. A. 11, n.8). Therefore, they cannot pursue this claim upon this writ. *See Monks* v. *New Jersey*, 398 U.S. 71 (1970) (writ of certiorari dismissed where state courts had no opportunity to pass on the issue raised). It is also noteworthy in this regard that the Supreme Judicial Court has already held, in a prior decision, that the statutory recoupment authority challenged here is a valid exercise of the Legislature's police powers. *Risk Management Foundation of Harvard Med. Institutions, Inc.* v. *Commissioner of Ins.*, 554 N.E.2d 843, 847-48 (Mass. 1990).

[7] As noted above, the Court should also bear in mind that the MMPIA is currently sponsoring legislation that would eliminate the deficit recoupment authority. *See* Senate Bill 1596, A17-A23.

unable to establish that they were deprived of any protectible property interest. The deficit recoupment statute is part of the original enabling legislation that established the MMPIA "to provide medical malpractice insurance on a self-supporting basis." St. 1975, c. 362, § 6. In order to be self-sustaining, the MMPIA was given the authority pursuant to Paragraph 7 of § 6 of the Enabling Act, to recoup any deficit for any year by either an assessment, a prospective rate increase, or both, and the petitioners took their policies subject to this deficit recoupment power. *See Home Bldg. & Loan Ass'n* v. *Blaisdell*, 290 U.S. 398, 429-30 (1934). "[T]he laws which subsist at the time and place of the making of a contract, and where it is to be performed, enter into and form a part of it, as if they were expressly referred to or incorporated in its terms."). (Citatations omitted).

Given the statutory authority to recoup deficits, which predated any interest that the petitioners may have in the medical malpractice rates charged by the MMPIA, they cannot and do not have a constitutionally protected property interest in preserving the level of malpractice premiums they originally paid. *See Board of Regents* v. *Roth*, 408 U.S. 564, 577-78 (1972); *Great N. Ry.* v. *Sunburst Oil & Ref. Co.*, 287 U.S. 358, 361-62 (1932). The failure to demonstrate such an interest is fatal to their procedural due process claim, and the Supreme Judicial Court properly rejected it.

II. CONTRACTS CLAUSE.

A. *The Supreme Judicial Court Correctly Held That a Prospective Rate Increase Does Not Affect Any Pre-Existing Contracts And Therefore Could Not Violate The Contracts Clause.*

The petitioners' Contracts Clause argument also misstates the issue that was decided by the Supreme Judicial Court. The questions is not "whether an unconstitutional impairment of contract occurs when a subsequently enacted statute is used

to substantially alter the obligation of an existing contract" (Pet. 9); rather, the question is whether the *prospective* rate increase being challenged here affects existing contracts at all. The Supreme Judicial Court correctly found that it does not.

The statute that the petitioners challenge under the Contracts Clause is St. 1980, c. 333, which amended the MMPIA's Enabling Act to eliminate the assessment mechanism for recoupment of deficits, leaving a prospective rate increase as the only recoupment method. See Pet. 11-12, stating their "core" claim. As originally enacted, the Enabling Act read:

> Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by [an assessment upon the policyholders, or] a rate increase applicable prospectively[, or both]; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term 'policyholders' shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not."

St. 1975, c. 362, § 6. The bracketed language was eliminated by St. 1980, c. 333, which left in place "a rate increase applicable prospectively" as the sole method for the MMPIA to recoup deficits.

Prior to the enactment of St. 1980, c. 333, the MMPIA's policies contained an endorsement that put its policyholders on notice that they were subject to assessments to recoup deficits. For example, the 1977 policy stated:

> The policy is assessable pursuant to Section 6 of Chapter 362 of the Acts of 1975. Any deficit sustained by the Medical Malpractice Joint Underwriting Association in any one year shall be recouped by an assessment upon all medical malpractice insurance policyholders, whether insured through the Joint Underwriting Association or otherwise. It is agreed, therefore, that in addition to any other premium due under this policy, an assessment shall be payable if and when a deficit is declared by the Board of Directors of said Association.

The petitioners contend that the MMPIA, by the use of this language, committed itself to recouping deficits *solely* by means of assessments and *not* via a prospective rate increase. Thus, the petitioners argue, the MMPIA's attempt to recoup deficits by the prospective rate increase method that has always been authorized by its Enabling Act is an impairment of their pre-1980 insurance policies.[8]

The Supreme Judicial Court correctly rejected this argument on the straightforward basis that "a rate increase applicable prospectively" cannot violate the Contracts Clause, which "applies only to laws with retrospective, not prospective, effect." (Pet. A7); (quoting *Local Div. 589, Amalgamated Transit*

[8] In fact, the petitioners go further and argue that even though the MMPIA's policies subsequent to the enactment of St. 1980, c. 333 do not contain the assessment endorsement, the MMPIA is nonetheless bound to recoup deficits from those policy years solely by means of assessments because the MMPIA did not expressly terminate the endorsement. (Pet. 11).

Union v. *Commonwealth*, 666 F.2d 618, 637 (1st Cir. 1981), *cert. denied*, 457 U.S. 1117 (1982) (citing *Ogden* v. *Saunders*, 25 U.S. [12 Wheat.] 213 (1827)). In reaching this conclusion, the Supreme Judicial Court determined that "[the petitioners] simply fail to distinguished between actions taken by the MMPIA under its existing contracts with policyholders and actions taken by the Legislature and the MMPIA regarding the terms of the MMPIA's future contracts." (Pet. A7). The court noted that under the statute, a prospective rate increase to recoup deficits applies to all medical malpractice insureds regardless of whether they have ever had a policy with the MMPIA, so that "it is clear that the application of that increase cannot be part of past MMPIA contracts."[9] (Pet. A8). Furthermore, "[the petitioners] will not themselves be subject to any eventual rate increases under the deficit recoupment statute if they are not insured under malpractice policies in Massachusetts at the time such increases are imposed." *Id.*

The petitioners attempt to duck the Supreme Judicial Court's fatal blow to their Contracts Clause theory by seeking refuge in the general statement set forth in *General Motors Corp.* v. *Romein*, ___ U.S. ___, 112 S.Ct. 1105, 1109-10 (1992), that a contract clause analysis

> has three components: whether there is a contractual relationship, whether a change in law impairs that contractual relationship, and whether the impairment is substantial. Normally, the first two are unproblematic, and we need address only the third.

[9] The constitutionality of that aspect of the MMPIA's Enabling Act was upheld by the Massachusetts Supreme Judicial Court in *Risk Management Foundation* v. *Commissioner of Ins.*, 554 N.E.2d 843 (Mass. 1990), and is not before this Court.

The petitioners' conclusory assertions to the contrary notwithstanding, the Massachusetts Supreme Judicial Court found the second component, whether there is an impairment at all, to be not only problematic but dispositive.

Any rate increase to recoup deficits for prior years will apply to the petitioners if, and only if, they are medical malpractice policyholders in Massachusetts when, and only when, such a prospective rate increase is approved by the Commissioner and goes into effect. The petitioners' liability for such an increase is entirely independent of their earlier contracts with the MMPIA. Accordingly, the petitioners' argument that they whould be shielded from this liability by the fortuity that they were policyholders at a time when policyholders were *also* subject to recoupment by assessment was properly addressed by the Supreme Judicial Court and does not merit consideration by this Court.

Because the Supreme Judicial Court determined that St. 1980, c. 333 did not impair petitioners' contracts, it did not reach the principal arguments pressed by the Petition that the nonexistent impairment was substantial. However, even if this Court were to consider that issue, the undisputed facts compel the conclusion that any impairment that the petitioners might attempt to prove was both insubstantial and justified by the statute's important public purpose.

The change in recoupment method from assessment to prospective rate increase did not substantially alter the expectations of the parties to these policies. All physicians and hospitals in Massachusetts were at all times on notice of their potential liability for deficits sustained by the MMPIA. From its inception, the MMPIA was empowered to recoup deficits, first by means of an assessment, a prospective rate increase, or both, and then by a rate increase alone. Even if the policyholders had an expectation that the MMPIA would only use the assessment power, a prospective rate increase does not substantially

alter that expectation. *See Energy Reserves Group* v. *Kansas Power & Light*, 459 U.S. 400, 411 (1983) ("state regulation that restricts a party to gains it reasonably expected from the contract does not necessarily constitute a substantial impairment"). Additionally, because the MMPIA is not only heavily regulated, but state created and mandated, the petitioners were on notice that the Legislature might amend the recoupment power and thereby alter their expectations. *See Energy Reserves*, 459 U.S. at 411 (when a person engages in "an enterprise already regulated in the particular to which he now objects, he [does so] subject to further legislation upon the same topic.").

In any event, there is no evidence that the petitioners' liability would increase under the prospective rate increase method of deficit recoupment as opposed to assessments. The petitioners admit as much, arguing only that they "did not bargain to be members of a *potentially and/or actually different, and possibly even smaller* pool of ratepayers who might exist when the MMPIA finally got around to levying a prospective rate increase." (Pet. 15) (emphasis added). As the Supreme Judicial Court held, that wholly unsupported and speculative concern does not constitute evidence of any actual harm to the petitioners arising out of the amendment (Pet. A12); a finding which would not be disturbed by this Court. *Fry Roofing Co.*, 344 U.S. at 159-160.

Moreover, even if some impairment of the petitioners' contract could be hypothesized, it would pale in comparison to the important public purpose served by the statute being challenged. As the Supreme Judicial Court has previously held:

> Clearly, c. 333 bears a substantial relation to the public health. The [MMPIA] was created to guarantee that medical malpractice insurance would remain available so as to ensure that doctors continue to

> practice and that hospitals continue to operate in the Commonwealth. In order to maintain the viability of the [MMPIA], the Legislature could reasonably turn to doctors and hospitals in the event of a deficit. These groups, it should be noted, benefit from the existence of the [MMPIA], in that [MMPIA] insurance was and is available to them, and in that the [MMPIA's] presence helps to maintain the smooth operation of the medical care marketplace.

Risk Management Foundation v. *Commissioner of Ins.*, 554 N.E.2d 843, 848 (Mass. 1990). Any impairment of contract, if one could be found in this case, "must be accommodated to the inherent police power of the State to safeguard the vital interests of its people." *Energy Reserve Group*, 459 U.S. at 410.[10] However, since the Supreme Judicial Court correctly decided that there was no impairment of contract here, there is no basis for the petitioners to impose on this Court to address the issue. *See General Motors*, 112 S.Ct. at 1110.

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[10] The petitioners argue that the MMPIA should be subject to the "heightened standard of review" courts apply where a law impairs the state's own contracts (Pet. 12-13). In those cases, a court's usual "deference to a legislative assessment of reasonableness and necessity is not appropriate." *U.S. Trust Co.* v. *New Jersey*, 431 U.S. 1, 26 (1977). The MMPIA is a self-supporting entity that does not rely on state funding; the state's self interest, which is cited as the basis for imposing a heightened standard, is not present here. In any event, even under the "heightened" standard urged by the petitioners, there was sufficient justification for any impairment that might be attributed to St. 1980, c. 333.

CONCLUSION.

For all of these reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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C. 175A

§ 5A. Medical Malpractice Insurance.

The commissioner shall, annually on or before March first with respect to each twelve month period commencing on the following July first, after due hearing and investigation, fix and establish fair and reasonable classification of risks and adequate, just, reasonable and nondiscriminatory premium charges on claims made and occurrence basis to be used and charged by companies in connection with the issue or execution of medical malpractice insurance during the twelve month period commencing July first in said calendar year or any part of said twelve month period. In connection with any such hearing, the advisory filing of the Joint Underwriting Association established pursuant to section six of chapter three hundred sixty-two of the acts of nineteen hundred and seventy-five and any insurance company shall be filed with the commissioner on or before April first of the calendar year preceding the calendar year in which the decision is to be issued, advisory filings of any other parties to the hearing shall be filed on or before May fifteenth of such calendar year, and the hearing shall be commenced on or before July first of such calendar year; provided, however, that the advisory filing for said association for the twelve month period beginning July first, nineteen hundred and eighty-seven shall be filed with the commissioner on or before September first, nineteen hundred and eighty-six and other advisory filings for said period shall be filed on or before October first, nineteen hundred and eighty-six. The commissioner shall consider whether it is advisable to and establish limited practice classification of risks within each classification of risk established pursuant to this section. In fixing and establishing premium charges in accordance with

the provisions of this section, the commissioner shall prorate equally all charges to the insured according to actual calendar days of coverage. The effective dates of procurement or cancellation of insurance from insurance companies shall determine the cost to the insured for each coverage on an equal per diem basis established for the calendar year cost of insurance policies. The commissioner shall, on or before said date, sign memoranda of the classifications and premium charges fixed and established by him in such form as he may prescribe and file the same in his office and cause a duly certified copy of such classifications and schedule of premium charges forthwith to be transmitted to each company authorized to issue such policies. During said calendar year, the classification and premium charges fixed and established by the commissioner from such policies may be used as a maximum charge by a company issuing such policies, however such premiums below the premiums established by the commissioner shall be uniform for all such classifications throughout the commonwealth. Such deviation shall be filed with the commissioner and he shall allow such deviation only if the commissioner finds that the premium charges the insurer desires to use are adequate, just, reasonable and nondiscriminatory and will not be used by the insurer as a means of attracting only such risks as are regarded as presenting less hazard of loss than others in the same classification. Every application for permission to so deviate shall be filed with the commissioner subsequent to and within thirty days of his having filed in his office the memorandum aforesaid and shall specify the basis thereof and shall be accompanied by the data upon which the applicant relies. The commissioner shall then set the time and the place for a hearing on such applications at which the applicant may be heard and shall give the applicant not less then ten days written notice thereof. The time so established for the hearing shall not be later than thirty days after receipt by the commissioner of the application.

If the commissioner finds that the deviation is justified and the resulting premium charges satisfy the requirements of this section, he shall issue an order permitting the deviation to be used by the applicant for the ensuing calendar year beginning January first.

In fixing and establishing the charges, as provided in this section, the commissioner shall take into account investment income and potential income from unearned premiums, loss reserves and all cash flows.

The commissioner may make, and at any time, alter or amend, reasonable rules and regulations to facilitate the operation of this section and enforce the application of the classifications and premium charges fixed and established by him, and to govern hearings and investigations under this section. The commissioner may at any time require any company to file with him such data, statistics, schedules or information as he may deem proper or necessary to enable him to fix and establish or secure and maintain fair and reasonable classifications of risks and adequate, just, reasonable and nondiscriminatory premium charges for such policies. Every company selling medical malpractice insurance coverage in the commonwealth shall file with the commissioner complete financial records showing the amount of profit or loss made on every classification of medical malpractice insurance during the previous year, and shall also file records showing profits from investment income including investment income on net realized capital gains and loss reserves and unearned premiums. The commissioner may issue such orders as he finds proper, expedient or necessary to enforce and administer the provisions of this section, to secure compliance with any rules or regulations made thereunder, and to enforce coherence to the classifications and premium charges fixed and established by him. The supreme judicial court for the county of Suffolk shall have jurisdiction upon the complaints of the commissioner and upon a summary

hearing, to enforce all lawful orders of the commissioner. Memoranda of all actions, orders, findings and decisions of the commissioner shall be signed by him and filed in his office as public records open to public inspection. A copy of all such memoranda shall be sent to the Special Commission on Medical Malpractice established pursuant to chapter three hundred and sixty-two of the acts of nineteen hundred and seventy-five.

Any person or company aggrieved by any action, order, finding or decision of the commissioner under this section may, within twenty days from the filing of such memorandum thereof in his office, file a complaint in the supreme judicial court for the county of Suffolk for a review of such action, order, finding or decision. An order of notice returnable not later than seven days from the filing of such complaint shall forthwith issue and be served upon the commissioner. Within ten days after the return of said order of notice, the complaint shall be assigned for a speedy and summary hearing on the merits. The action, order, finding or decision of the commissioner shall remain in full force and effect pending the final decision of the court unless the court or a justice thereof after notice to the commissioner shall by a special order otherwise direct. The court shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order, finding or decision, shall review all questions of fact and of law involved therein and may make any appropriate judgment. The decision of the court shall be final and conclusive on the parties. The court may make such order as to costs as it deems equitable. The court shall make such rules or orders as it deems proper, governing proceedings under this section to secure prompt and speedy hearings and to expedite final decisions thereon.

If, for any reason, classifications of risks and premium charges fixed and established as aforesaid on or before March first in any year for the ensuing twelve month period are not effective for said year, the commissioner shall establish the

classifications of risks and premium charges requested by one of the interested parties for the ensuing year as an interim rate until classifications of risks and premium charges for said ensuing twelve month period are finally fixed and established. Classifications of risks and premium charges when finally fixed and established for said ensuing calendar year shall become effective as of July first of said twelve month period, and all premium charges affected by any change thereby made which have been paid or incurred prior to the time when such charges are finally fixed and established shall be adjusted in accordance with such change, as of said July first.

Every mutual company issuing medical malpractice insurance policies shall constitute such policies as a separate class of business for the purpose of paying dividends. Any dividends on such policies shall be declared on the profits of the company from said class of business.

Insurance companies shall, at the option of the insured, accept payment of medical malpractice insurance premiums in installments under plans, rates and charges approved by the commissioner, after such notice as shall be prescribed by the commissioner and after public hearing thereof, provided, however, that each insurance company shall offer at least one installment payment plan for each policy which either gives the insured the option to pay the annual premium in a minimum of six monthly installments or gives the insured the option to pay the annual premium in four quarterly installments.

Effective sixty days after the inception of a medical malpractice insurance contract no notice of intention to terminate the contract or, if the contract is a renewal, no notice of intention not to renew the contract shall be effective unless the insurer at least ninety days prior to the effective date of such cancellation or the end of the contract period, as the case may be, mails or delivers to the insured at the address shown on the policy such notice of cancellation or intention not to renew

except where the cancellation is for nonpayment of premium, or where the insured has lost his license to practice medicine, or if the insured is a hospital, no longer possesses a valid operating certificate.

For the purposes of this section, a medical malpractice insurance contract shall mean in insurance contract covering liability arising out of the practice of medicine by a duly licensed physician or the operation of a duly certified hospital with respect to the treatment of patients, including all acts of its agents and employees. (1975, 362, § 4; 1977, 613; 1986, 351, §§ 15-17, approved July 23, 1986; by § 41, effective October 1, 1986.)

Chapter 351. An Act Relative to Medical Malpractice.

Be it enacted, etc., as follows:

SECTION 2. Section 32 of said chapter 6A, as so appearing, is hereby amended by inserting after the fourth paragraph the following four paragraphs: —

In determining rates to be paid to providers of health care services, by governmental units, and by insurers under chapter one hundred and fifty-two, the commission shall adjust such rates effective July first, nineteen hundred and eighty-seven and each July first thereafter through and including July first, nineteen hundred and ninety-one, for changes in medical malpractice insurance premiums fixed and established pursuant to section five A of chapter one hundred and seventy-five A for such providers of health care services.

The total adjustments shall be sufficient to generate, over a twelve-month period, additional payments to physicians or dentists equal to the total dollar increase in medical malpractice insurance premium charges over the charges which were in effect prior to the decision to fix and establish new premium charges, multiplied by the following fraction: (a) The numerator shall be the percent of total revenues for physicians, or dentists, which are paid by governmental units as to which the rates of payment are fixed and established by the rate setting commission pursuant hereto, plus the percent of total revenues for physicians, or dentists, which are paid by insurers under chapter one hundred and fifty-two; and (b) The denominator shall

be one hundred percent minus the percent of total revenues for physicians, or dentists, paid by medical service corporations under policies providing supplemental coverage to health insurance under Title XVIII of the Social Security Act. The percent amounts specified for the numerators and denominators above, and the amount of the total dollar increase in medical malpractice insurance premium charges shall be the amounts determined by the commissioner of insurance pursuant to section five B of chapter one hundred and seventy-five A. In the event that medical malpractice insurance premium charges decrease, negative adjustments shall be made pursuant to the same formula.

The adjustments shall take effect with the next routinely-scheduled change in payments or rates following the change in medical malpractice insurance premiums. The commission shall make available a list of the adjustments, by procedure or procedure code, that have been made pursuant to this paragraph.

Whenever the premiums or rates of worker's compensation insurance are subject to regulation of the commissioner of insurance, the commissioner shall allow such insurer to include within its premiums, rates or subscription charges such adjusted payments, effective as of the date that such adjusted payments were first implemented.

ACTS, 1986. — Chap. 351.

SECTION 15. The first paragraph of section 5A of chapter 175A of the General Laws, as appearing in the 1984 Official Edition, is hereby amended by striking out the first sentence and inserting in place thereof the following three sentences: — The commissioner shall, annually on or before March first with respect to each twelve month period commencing on the

following July first, after due hearing and investigation, fix and establish fair and reasonable classification of risks and adequate, just, reasonable and nondiscriminatory premium charges on claims made and occurrence basis to be used and charged by companies in connection with the issue or execution of medical malpractice insurance during the twelve month period commencing July first in said calendar year or any part of said twelve month period. In connection with any such hearing, the advisory filing of the Joint Underwriting Association established pursuant to section six of chapter three hundred sixty-two of the acts of nineteen hundred and seventy-five and any insurance company shall be filed with the commissioner on or before April first of the calendar year preceding the calendar year in which the decision is to be issued, advisory filings of any other parties to the hearing shall be filed on or before May fifteenth of such calendar year, and the hearing shall be commenced on or before July first of such calendar year; provided, however, that the advisory filing for said association for the twelve month period beginning July first, nineteen hundred and eighty-seven shall be filed with the commissioner on or before September first, nineteen hundred and eighty-six and other advisory filings for said period shall be filed on or before October first, nineteen hundred and eighty-six. The commissioner shall consider whether it is advisable to and establish limited practice classification of risks within each classification of risk established pursuant to this section.

SECTION 17. Said section 5A of said chapter 175A, as so appearing, is hereby further amended by striking out the sixth paragraph and inserting in place thereof the following paragraph: —

If, for any reason, classifications of risks and premium charges fixed and established as aforesaid on or before March

first in any year for the ensuing twelve month period are not effective for said year, the commissioner shall establish the classifications of risks and premium charges requested by one of the interested parties for the ensuing year as an interim rate until classifications of risks and premium charges for said ensuing twelve month period are finally fixed and established. Classifications of risks and premium charges when finally fixed and established for said ensuing calendar year shall become effective as of July first of said twelve month period, and all premium charges affected by any change thereby made which have been paid or incurred prior to the time when such charges are finally fixed and established shall be adjusted in accordance with such change, as of said July first.

SECTION 18. Said chapter 175A is hereby further amended by inserting after section 5A the following section: —

Section 5B. On or before September first of the calendar year preceding the date by which the commissioner shall fix and establish classifications of risks and premium charges pursuant to section five A of chapter one hundred and seventy-five A, each medical service corporation shall file with the commissioner of insurance such data as will show the percentage of total revenues for physicians and for dentists in Massachusetts, which is attributable to payments by it which are subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B, and the percentage of such total revenues which is attributable to payments by it under policies providing supplemental coverage to health insurance provided under Title XVIII of the Social Security Act. Any interested party, including, without limitation, organizations of physicians or dentists and agencies of the commonwealth or of the United States, may file, within the same time period, data relating to the total revenues for physicians or

dentists in Massachusetts and the percentage share thereof paid by:

(a) medical service corporations for services which are subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B;

(b) governmental units as to which the rates of payment for professional services to physicians or dentists are fixed and established by the rate setting commission pursuant to section thirty-two of chapter six A;

(c) insurers under chapter one hundred and fifty-two;

(d) health insurance under Title XVIII of the Social Security Act;

(e) medical service corporations under policies providing supplemental coverage to health insurance provided under Title XVIII of the Social Security Act; and

(f) all other payors, including, without limitation, medical service corporations to the extent their payments are not included in items (a) to (e), inclusive.

The commissioner of insurance may require any insurer, health maintenance organization or other payor making payments to physicians or dentists in the commonwealth for medical or dental services, to file such data as will show that payor's total payments to physicians or dentists in the commonwealth during such prior time period as the commissioner of insurance shall specify, and such other or further data as may be necessary to carry out the provisions of this section.

No later than November first, the commissioner shall hold a hearing to determine, based on the data filed by medical service corporations or any other party, or on other data or reasonable estimates available to him and introduced into the record in the said hearing, the percentage share of total revenues for physicians and the percentage share of total revenues for dentists, in Massachusetts, paid by the following:

(a) medical service corporations for services which are subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B;

(b) governmental units as to which the rates of payment for professional services to physicians or dentists are fixed and established by the rate setting commission pursuant to section thirty-two of chapter six A;

(c) insurers under chapter one hundred and fifty-two;

(d) health insurance under Title XVIII of the Social Security Act;

(e) medical service corporations under policies providing supplemental coverage to health insurance under Title XVIII of the Social Security Act; and

(f) all other payors, including, without limitation, medical service corporations to the extent their payments are not included in items (a) to (e), inclusive. Said determination shall be made no later than March first of the succeeding calendar year.

Any interested party, which has filed data relating to the said percentages of total revenues for physicians and dentists and the medical malpractice analysis bureau, shall be entitled to participate in the hearing thereon, to present oral and written evidence, to examine and cross-examine witnesses, to review all information and materials filed with or relied on by the commissioner of insurance, and to submit briefs or position papers to any determination by the commissioner of insurance.

Any interested party which has participated in the said hearing and which is aggrieved by any action, order, finding or decision of the commissioner of insurance under this section may, within twenty days from the filing of his decision thereof in his office, file a complaint in the supreme judicial court for the county of

Suffolk for a review of such action, order, finding or decision, and serve a copy thereof upon the commissioner of insurance and the attorney general. Within twenty days after the service of said complaint, the complaint shall be assigned for a speedy and summary hearing on the merits. The action, order, finding or decision of the commissioner of insurance shall remain in full force and effect pending the final decision of the court. The court shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order, finding or decision, but such action, order, finding or decision shall not be modified, amended, annulled or reversed, unless the court finds that the commissioner of insurance erred as a matter of law, or that the decision was unsupported by any evidence in the record, with every reasonable inference in support of the decision made therefrom. The decision of the court shall be final and conclusive on the parties. The court shall make such rules or orders as it deems proper governing proceedings under this section to secure prompt and speedy hearings and to expedite final decisions thereon. In the event that the court modifies, amends, annuls or reverses such action, order, finding or decision, the decision of the court shall be implemented by the commissioner in the next hearing, commenced pursuant to this section, following said decision.

Payment made by any medical service corporation relating to services subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B which are rendered by participating physicians or dentists covered by policies of medical malpractice insurance shall be adjusted for changes in medical malpractice premium charges fixed and established pursuant to section five A of chapter one hundred and seventy-five A. The medical service corporations payment shall be the amount of the total malpractice adjustment for that procedure code in addition to the amount paid to the physician for that procedure.

The total adjustments shall be sufficient to generate, over a twelve-month period, additional payments to physicians or dentists equal to the total dollar increase in medical malpractice insurance premium charges over the charges which were in effect prior to the decision to fix and establish new premium charges, multiplied by the following fraction: (a) The numerator shall be the percent of total revenues for physicians, or dentists, which the medical service corporation's payments for services subject to the limitations of section seven of chapter one hundred and seventy-six B constitute, plus one-half of the percent of total revenues for physicians, or dentists, paid by health insurance under Title XVIII of the Social Security Act; and (b) The denominator shall be one hundred percent minus the percent of total revenues for physicians, or dentists, paid by the medical service corporation under policies providing supplemental coverage to health insurance under Title XVIII of the Social Security Act. In the event that medical malpractice insurance premium charges decrease, negative adjustments shall be made pursuant to the same formula.

Any participating physician or participating dentist, when filing a request for payment based on a procedure code with said corporation, shall be allowed to include the dollar amount of the total adjustment allocated for that procedure code; provided, however, that said dollar amount shall not be separately stated. Upon submission of such dollar amount by the physician, the medical service corporation shall include all of that dollar amount in the amount paid to the physician for that procedure code. No change in medical malpractice insurance premium charges shall be approved by the commissioner of insurance until he has determined the percentage shares of total revenues for physicians or dentists paid by the medical service corporations and others as provided above. The adjustment to payments by the medical service corporation shall take effect with the next regularly scheduled change in payments

following the change in medical malpractice insurance premiums. The medical service corporation shall make available to participating physicians and dentists a list of the adjustments by the procedure code that have been made prior to the next regularly scheduled change in payments. The medical service corporation shall also provide said list to the division of insurance, which shall make available such list upon request.

In determining the total adjustment that shall be made to participating physicians and participating dentists for the twelve month period beginning July first, nineteen hundred and eighty-seven, the commissioner shall include in the calculation of total adjustment increases in medical malpractice insurance premium charges made for the twelve month period beginning July first, nineteen hundred and eighty-six; provided, further, that in calculating the total adjustment to be made by the medical service corporation for the twelve month period beginning July first, nineteen hundred and eighty-seven, the commissioner shall allow a credit for the aggregate amount of physician reimbursements made pursuant to increases in medical malpractice premiums by the Joint Underwriters Association made by said medical service corporation effective July first, nineteen hundred and eighty-six.

Whenever the premiums, rates or subscription charges of a medical service corporation are subject to regulation by the commissioner of insurance, the commissioner of insurance shall allow such corporation to include within its premiums, rates or subscription charges such adjusted payments to participating physicians and participating dentists, effective as of the date that such adjusted payments were first implemented. Nothing in this paragraph or the preceding paragraph shall be construed to affect the responsibilities and authority of the commissioner of insurance under chapter one hundred and ninety-nine of the acts of nineteen hundred and eighty-four. This paragraph shall not apply to payments made for charges

regulated by chapter three hundred and ten of the acts of nineteen hundred and eighty-four.

The provisions of this section shall terminate upon the completion of the rate period ending June thirtieth, nineteen hundred and ninety-two.

The commissioner shall determine the methodology pursuant to which each medical service corporation shall allocate the total adjustments among procedure codes in order that payments to physicians and dentists are apportioned among the risk classifications established by the commissioner under section five A. The methodology will provide for application of the adjustments to usual charge levels for each physician or dentist and to customary charge levels, in each instance separately stated by procedure code for purpose of this section the commissioner shall make this determination on a biannual basis provided however that upon the motion of any party at any future hearing under this section. The commissioner shall review the methodology previously approved by him and approve such changes as may be necessary in order that the allocation methodology apportion such payments in accordance with this paragraph.

The provisions of this section shall terminate upon the completion of the rate period ending June thirtieth, nineteen hundred and ninety-two.

SENATE . . . . . No. 1596

By Mr. Berry, a petition (accompanied by bill, Senate, No. 1596) of Frederick E. Berry for legislation to convert the Medical Professional Insurance Association into the Medical Professional Mutual Insurance Company. Insurance.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Ninety-Four.

AN ACT CONVERTING THE MEDICAL PROFESSIONAL INSURANCE ASSOCIATION INTO THE MEDICAL PROFESSIONAL MUTUAL INSURANCE COMPANY.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The commissioner of insurance is hereby authorized and directed to approve the conversion of the Association and the Association is hereby converted into a mutual insurance company to be known as the Medical Professional Mutual Insurance Company, which shall succeed to and assume all of the assets and liabilities of the Association. All rights, interests and properties of the Association shall, without any further act or deed, be the property of the resulting mutual company, and the resulting mutual company shall remain bound by all obligations of the Association under policies of

insurance issued by it. No contracts, claims, suits or other rights of or against the Association shall be affected by this conversion.

SECTION 2. Section 13 of Chapter 362 of the Acts of 1975, as most recently amended by Section 11 of Chapter 65 of the Acts 1992, is hereby further amended by striking out the second sentence of said section and inserting in place thereof the following sentence: "Section six of this Act shall terminate upon the conversion of the joint underwriting association into the Medical Professional Mutual Insurance Company."

SECTION 3. The Medical Professional Mutual Insurance Company shall be authorized to transact any and all kinds of insurance, as the commissioner shall approve. Except as provided herein, or in its articles of organization or bylaws, such company shall have all powers conferred upon a mutual insurance company incorporated in the commonwealth and shall be subject to all provisions of the General Laws which are now or may in the future be applicable to such companies.

SECTION 4. The Medical Professional Mutual Insurance Company shall be governed until the annual meeting of the company held in 1997 by the Board of Directors of the Association as constituted on the date of the conversion of the Association into the company, subject to filling vacancies as provided in the company's bylaws. Thereafter, the company shall be governed by a board of not less than eleven directors, which may be divided into classes pursuant to section 77 of Chapter 175 of the General Laws, and shall, notwithstanding any other provision of law, be selected in the manner set forth in the company's bylaws.

SECTION 5. Notwithstanding any other provision of any general or special law, the Medical Professional Mutual Insurance Company shall:

(a) not establish a guarantee capital, nor shall it be subject to any of the provisions of chapter one hundred and seventy-five of the General Laws providing for voting rights by shareholders in any such guarantee capital, provided that nothing herein shall preclude the company from establishing a guarantee fund in accordance with the General Laws;

(b) not be subject to the provision of sections seventy-three, ninety A, ninety C, ninety-two, ninety-three A and ninety-three B of said chapter one hundred and seventy-five, insofar as they relate to subscriptions for insurance or securing initial applications for insurance;

(c) not be subject to the provisions of the first paragraph of sections fifty-eight and fifty-nine of said chapter one hundred and seventy-five; and

(d) be authorized to issue nonassessable polices.

SECTION 6. Upon approval of the commissioner, the Medical Professional Mutual Insurance Company may for any purposes, including, but not limited to the fixing of separate percentages of dividends under section eighty of chapter one hundred and seventy-five, consider the business of each category of health care provider as a separate line of business; provided further, however, that the doctor of dental science category of insured shall continue to be treated as a separate line of business to the extent required by Chapter 92 of the Acts of 1991.

SECTION 7. Section 5A of Chapter 175A of the General Laws is hereby repealed. The Medical Professional Mutual Insurance Company shall remain subject to the remaining provisions of said Chapter 175A to the extent that those provisions

otherwise apply to a mutual insurance company incorporated in the commonwealth.

SECTION 8. (a) As used in this section, the following words shall have the following meaning:

"Medical malpractice insurance," insurance coverage against the legal liability of the insured for loss, damage or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any health care provider.

"Medical malpractice insurer," an insurer authorized to write and engaged in writing medical malpractice insurance within the commonwealth on a direct basis.

"Net direct premiums," gross direct premiums written on personal injury liability insurance written pursuant to the provisions of chapter one hundred and seventy-five of the General Laws, including the liability component of multiple peril package policies as computed by the commissioner less all premiums and dividends credited or returned to policyholders or the unused or unabsorbed portions of premium deposits.

"Health care provider," any doctor of medicine, osteopathy, optometry, dental science, podiatry, chiropractic, or a registered nurse licensed under the provisions of chapter one hundred and twelve of the General Laws, an intern, fellow, or medical officer licensed under section nine of said chapter one hundred and twelve, or a licensed hospital, clinic, or nursing home, and its agents and employees.

"Medical Malpractice Analysis Bureau, the Medical Malpractice Analysis Bureau established in the Division of Insurance pursuant to Section 8I of Chapter 26 of the General Laws.

(b) All medical malpractice insurers shall accept the assignment of risks by the Medical Malpractice Analysis Bureau on a non-discriminatory basis as provided in this section. Any licensed health care provider upon proof that the health care

provider has made a reasonable effort to obtain insurance and has been unable to obtain it shall be entitled to apply through the Medical Malpractice Analysis Bureau for such coverage. Such application may be made on behalf of an applicant by a broker or agent authorized by the applicant. If the Bureau determines that the applicant meets the underwriting standards of the Bureau and there is no unpaid, uncontested premium due from the applicant for prior insurance as shown by the insured having failed to make written objection to premium charges within the thirty days after billing, it shall make an assignment of the risk to a medical malpractice insurer. The assignments of risk required by this section shall be allocated among medical malpractice insurers during any one calendar year in the proportion that the net direct premiums of each such insurer written during the preceding calendar year, excluding that portion of premiums attributable to the assignment of risks pursuant to this section written by such insurer during the preceding calendar year, bears to the aggregate net direct premiums written in the commonwealth by all medical malpractice insurers during the preceding calendar year. Each insurer's allocation of assigned risks pursuant to this section shall be determined annually on the basis of such net direct premiums written during the preceding calendar year as are reported in the annual statements and other reports filed by the insurer with the commissioner.

(c) Each company receiving assignments of risk pursuant to this section shall, as a condition of its authority to transact insurance within the commonwealth, cause to be issued to such approved applicant, upon receipt of the full annual premium, a policy of insurance for a term of one year. Following the one year policy term, any eligible applicant may apply through the Medical Malpractice Analysis Bureau for reassignment in the same manner as set forth above.

(d) The commissioner may make, and at any time alter or amend, reasonable rules and regulations to facilitate the operation of this section and to enforce the assignment of risks made by the Medical Malpractice Analysis Bureau pursuant to this section, including, but not limited to, regulations regarding the rates and the terms and conditions of the policies issued to such assigned risks.

SECTION 9. (a) Section 8I of Chapter 26 of the General Laws, as enacted by Section 4 of Chapter 351 of the Acts of 1986, is hereby amended by striking from the first sentence of the first paragraph the words "the medical malpractice joint underwriting association" and by inserting in place thereof the words "a medical malpractice insurer."

(b) Said section 8I of said Chapter is hereby further amended by inserting the following sentence after the first sentence in the first paragraph:

"The medical malpractice analysis bureau shall also oversee the assignment of health care provider risks, who are unable to obtain medical malpractice insurance, among the medical malpractice insurers writing in the commonwealth."

(c) Said Section 8I of said Chapter 26 is hereby further amended by striking from the first sentence of the second paragraph the words "the medical malpractice joint underwriting association" and inserting in place thereof the words "medical malpractice insurers."

(d) Said Section 8I of said Chapter 26 is hereby further amended by inserting the following sentence after the second sentence of the second paragraph: "The assessment shall be allocated among all medical malpractice insurers in the proportion that the net direct premiums of each such insurer written during the preceding calendar year, excluding that portion of premiums attributable to the assignment of risks pursuant to this section written by such insurer during the preceding calen-

dar year, bears to the aggregate net direct premiums written by all medical malpractice insurers during the preceding calendar year."

(e) Said Section 8I of said Chapter 26 is hereby further amended by striking from the third sentence of the second paragraph the words "joint underwriting association" and by inserting in place thereof the words "medical malpractice insurers."

(f) Said Section 8I of said Chapter 26 is hereby further amended by adding the following paragraph after the second paragraph:

"As used in this section the following words shall have the following meanings:

"Medical malpractice insurance," insurance coverage against the legal liability of the insured for loss, damage or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any health care provider.

"Medical malpractice insurer," an insurer authorized to write and engaged in writing medical malpractice insurance within the commonwealth on a direct basis.

"Net direct premiums," gross direct premiums written on personal injury liability insurance written pursuant to the provisions of chapter one hundred and seventy-five of the General Laws including the liability component of multiple peril package policies as computed by the commissioner less all premiums and dividends credited or returned to policyholders or the unused or unabsorbed portions of premium deposits.

"Health care provider," any doctor of medicine, osteopathy, optometry, dental science, podiatry, chiropractic, or a registered nurse licensed under the provisions of chapter one hundred and twelve of the General Laws, an intern, fellow, or medical officer licenses under section nine of said chapter one hundred and twelve, or a licensed hospital, clinic, or nursing home, and its agents and employees."

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No. 94-725

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994.

LIABILITY INVESTIGATIVE FUND EFFORT, INC.; LEONARD MORSE, M.D.; JUAN PENHOS, M.D.; WAYNE GLAZIER, M.D.; FRANCIS ROCKETT, M.D.; J. GORDON RICH, M.D.; AND JAMES BOYD, M.D.,

Petitioners,

v.

COMMONWEALTH OF MASSACHUSETTS; LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS

COMMONWEALTH'S BRIEF IN OPPOSITION

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Questions Presented

1. Does an insured have a property interest subject to procedural due process protection in expressly provisional medical malpractice insurance rates?

2. May an insured who fails to establish confiscation or other deprivation of property maintain a procedural due process claim premised upon delay in establishing prospective medical malpractice insurance rate increases to recoup deficits?

3. Does a statute that makes prospective rate increases the only method of recouping deficits of a self-supporting medical malpractice insurance joint underwriting association impair the obligations of insurance policies entered prior to its enactment but subsequent to the original statute that provided for recoupment by either assessments or prospective rate increases?

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Petitioners,

v.

COMMONWEALTH OF MASSACHUSETTS; LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS

COMMONWEALTH'S BRIEF IN OPPOSITION

Pursuant to Supreme Court Rule 15, the respondents Linda Ruthardt, Commissioner of Insurance for the Commonwealth of Massachusetts ("Commissioner"), and the Commonwealth of Massachusetts (collectively, "Commonwealth") submit this brief in opposition to the petition for writ of certiorari ("Pet.").

Decision Below

The opinion of the Massachusetts Supreme Judicial Court, reproduced at pages A1-A16 of the appendix to the petition ("Pet. App."), is reported at 418 Mass. 436, 636 N.E.2d 1317 (1994).

Jurisdiction

The opinion of the Supreme Judicial Court was entered July 21, 1994. See Pet. App. A1. The petition was filed October 18, 1994, and was received by the Commonwealth on October 18, 1994. The petitioners invoke the Court's jurisdiction pursuant to 28 U.S.C. § 1257(a).

Relevant Constitutional and Statute Provisions

The Commonwealth accepts the recitation of constitutional and statutory sections involved as set forth at pages 2-3 of the petition with certain additions:

The preamble to Mass. St. 1975, c. 362, provides:

> Whereas the deferred operation of this act would tend to defeat its purpose, which is, in part, to guarantee the continued availability of medical malpractice insurance . . . . [Preamble]

Mass. St. 1975, c. 362, § 6, provides in pertinent part:

> The purpose of the [MMPIA] shall be to provide medical malpractice insurance on a self-supporting basis. [second par.]

***

Said plan [of operation for the MMPAI] shall also provide that any profit achieved by the association shall be added to the reserves of the association or returned to the policyholders as a dividend. [fourth par.]

***

Any licensed physician or hospital upon proof that the physician or hospital has made a reasonable effort to obtain insurance and has been unable to obtain it shall be entitled to apply to the [MMPAI] for such coverage. [fifth par.]

***

Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by an assessment upon the policyholders, or a rate increase applicable prospectively, or both; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of phyisician or hospital malpractice coverage are being recouped, the term "policyholders" shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not. [seventh par., as originally

enacted]

The seventh paragraph of Mass. St. 1975, c. 362, § 6, was repealed and replaced by Mass. St. 1980, c. 333, which provided:

> Section 6 of chapter 362 of the acts of 1975 is hereby amended by striking out the seventh paragraph and inserting in place thereof the following paragraph:
>
> Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by a rate increase applicble prospectively; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term "policyholders" shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not.

Mass. St. 1986, c. 351, § 38, is accurately reproduced at pages A17-A20 of the appendix to the petition.

Statement of the Case

This case arises from the petitioners' attempts to challenge (1) the collection under Mass. St. 1986, c. 351, of premium rates finally established with respect to policies for the 1983 and 1984 rate years, where the initial rates were provisional under the express terms of the policies, and (2) the potential collection under Mass. St. 1975, c. 362, § 6, as amended by Mass. St. 1980, c. 333, of prospective rates in some future rate year to recoup deficits for operations in the 1975-82 years, *if* a deficit is found to exist in administrative proceedings. An accurate statement of the case appears at pages A3-A5 (opinion of the Massachusetts Supreme Judicial Court) of the appendix to the petition. However, the petition does not accurately describe the relevant background in at least six areas. As to those subjects, the Commonwealth also states as follows.

1. In describing the creation of the respondent Massachusetts Medical Professional Insurance Association ("MMPIA"), then named the Medical Malpractice Joint Underwriting Association (Pet. 3), the petitioners fail to note that the Massachusetts Legislature acted "to guarantee the continued availability of medical insurance" in the Commonwealth. St. 1975, c. 362, Preamble. See *Risk Management Foundation of Harvard Medical Institutions v. Commissioner of Insurance*, 407 Mass. 498, 500, 554 N.E.2d 843 (1990) ("*Risk Management*"). Section 6 of the statute established the MMPIA. The MMPIA is authorized to issue medical malpractice insurance policies to physicians and hospitals that have "made a reasonable effort to obtain insurance and [have] been unable to obtain it." *Id.* § 6, fifth par.

2. While the MMPIA was established by statute, the petitioners' implicit (Pet. 3) and later explicit (Pet. 12-13) claim that the policies issued by the MMPIA are obligations of the Commonwealth is wrong. The MMPIA was expressly created to provide insurance "on a self-supporting basis." St. 1975, c. 362, § 6, second par. To that end, the statute establishing the MMPIA authorized it to recoup deficits from policyholders. St. 1975, c. 362, § 6, seventh par. (originally and as amended by St. 1980, c. 333). In keeping with its self-supporting nature, the MMPIA is also authorized to return profits to policyholders. St. 1975, c. 362, § 6, fourth par. The Commonwealth does not financially support or benefit from the policies issued by the MMPIA.

3. The petitioners also erroneously assert that the insurance coverage provided by the MMPIA is "in no real sense insurance" because policyholders are subject to recoupment (Pet. 5). As the Supreme Judicial Court stated, "Insurance, however, involves not just the shifting of risk from insured to insurer, but also risk-sharing among insureds. The fact that the MMPIA will not suffer losses does not deprive the [petitioners] of insurance" (Pet. App. A12 n. 11). The MMPIA is an independent entity, subject to state regulation, similar to a mutual insurance company, whose members receive insurance coverage and accept the possibility of dividends if there is a profit but also of additional charges if a deficit occurs.

4. The petitioners erroneously assert that the action of the Commissioner in authorizing collection of additional premiums in June 1986 was recoupment of a deficit pursuant to St. 1975 c. 362 (Pet. 4). Petitioners omit the fact that the amounts allegedly "recouped" were the result of the usual ratesetting process and reflected the fact that the decision of the

Commissioner setting the premiums for the 1983-84 policy year (which were expressly provisional under the terms of the policies) was reversed on appeal. *Medical Malpractice Joint Underwriting Ass'n of Massachusetts v. Commissioner of Insurance*, 395 Mass. 43, 478 N.E.2d 936 (1985). The Legislature then froze the rates at the levels set in the initial decision. Mass. St. 1985, c. 671; Mass. St. 1986, c. 37. After the Commissioner issued his final rate decision, the Legislature removed the freeze and allowed the MMPIA to collect the difference between the provisional rates and the rates as finally determined, but only over a period of five years. Mass. St. 1986, c. 351, § 38(2), (3).[1]

5. Throughout the petition, petitioners confuse two separate statutes.

a. The Deferred Premium Liability Statute, St. 1986, c. 351, § 38 ("DPL Statute"), addressed the question of how to collect the "total deferred premium liability," defined as the outstanding premiums on 1983, 1984 and 1985 policies whose collection was delayed because the Legislature temporarily froze premiums at an interim level below that finally established by the Commissioner. Mass. St. 1986, c. 351, § 38(1). The DPL Statute provided for deferral of the amounts

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[1] This history, briefly summarized in the Supreme Judicial Court's decision (Pet. App. A4-A5), is set forth in more detail in earlier decisions of the Supreme Judicial Court. See *Massachusetts Medical Society v. Commissioner of Insurance*, 404 Mass. 720, 721, 537 N.E.2d 116 (1989), and *Liability Investigative Fund Effort, Inc. v. Medical Malpractice Joint Underwriting Association of Massachusetts*, 409 Mass. 734, 738, 569 N.E.2d 797 (1991).

due until July 1, 1987 and annual collection of predetermined portions of the total over a five-year period. St. 1986, c. 351, § 38(3). The DPL Statute thus concerned only amounts that were properly due as premiums under St. 1975, c. 362, § 6, *i.e.*, the rates the Commissioner had finally determined to be "adequate, just, actuarially sound and self supporting". The separate DPL rates and "pass-through" adjustments ended with the rate year 1991/92. *See* St. 1986, c. 351, §§ 38(3) and 18.

b. The recoupment provisions of St. 1975, c. 362, § 6, seventh par., as amended by St. 1980, c. 333 ("Recoupment Statute"), address a different problem: the recoupment of a "deficit." Such a deficit may result from rates that, while properly set initially, do not ultimately fully fund actual loss experience, loss related expenses and other obligations to policyholders. The recoupment provisions reflect the legislative intent that the MMPIA be "self-supporting," even if the rates set do not conform to actual experience and operations. St. 1975, c. 362, § 6, second par. In 1987, the MMPIA commenced an administrative proceeding before the Commissioner asking to recoup deficits for the 1975-82 period. That proceeding, which among other issues presents questions concerning the time period over which losses mature and thus deficits can be known to exist, is still pending, and there has been no determination whether any deficits actually exist.[2]

6. In their brief description of this action (Pet. 5-6), petitioners fail to mention that the Supreme Judicial Court had

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[2] Certain preliminary rulings in that proceedings were the subject of an interlocutory appeal to the Supreme Judicial Court. *Risk Management*, 407 Mass. 498.

issued an earlier decision reversing the Superior Court's initial dismissal of the action and remanding the case for an individualized determination whether each of the twenty-three counts of the complaint could be maintained in the Superior Court. *Liability Investigative Fund Effort, Inc. v. Medical Malpractice Joint Underwriting Association of Massachusetts*, 409 Mass. 734, 569 N.E.2d 797 (1991). On remand, the petitioners stipulated to the dismissal of all but four of the twenty-three counts of their complaint. As the Supreme Judicial Court noted (Pet. App. A9, A11 n. 9), petitioners stipulated to dismissal of the counts raising substantive due process and takings challenges.

Reasons for Denying the Writ

"A review on writ of certiorari is not a matter of right but of judicial discretion." Rules of the United States Supreme Court, Rule 10.1. Such a writ is to be granted "only when there are special and important reasons therefor." *Id.* The purpose of certiorari jurisdiction is to permit the Court to select cases of "such gravity and general importance" as to warrant plenary review. *In re Woods*, 143 U.S. 202, 206 (1892).

The petitioners do not claim that the Supreme Judicial Court of Massachusetts "has decided a federal question in a way the conflicts with the decision of another state court of last resort or of a United States court of appeals." Supreme Court Rule 10.1(b). Nor do they assert that the decision has importance beyond its application to the parties. They seem only to contend that the decisions may conflict with decisions of this Court.

For the reasons set forth below, these contentions lack

merit. As the petition does not satisfy the traditional criteria which guide the Court's discretionary review, it should be denied.

I. PETITIONERS' PROCEDURAL DUE PROCESS CLAIMS DO NOT WARRANT REVIEW BY THIS COURT.

In their first question, the petitioners ask the Court to review the Massachusetts Supreme Judicial Court's decision upholding the constitutionality of the DPL Statute and the Recoupment Statute against procedural due process challenge. This question does not warrant review because the due process issue turns predominantly on the peculiar history of Massachusetts medical malpractice ratesetting, which does not present questions of broad importance or conflict with decisions of this Court.

1. The petitioners assert that the due process issue they present is "important" because they "are being heavily burdened in the *present* for transactions which occurred in the *past*" (Pet. 7)(emphasis in original). However, with respect to the DPL Statute, the crux of the matter is that petitioners lack a protected property interest because the Supreme Judicial Court found that rates on which petitioners rely were provisional as a matter of state law.

In order to invoke the protection of the Due Process Clause, the petitioners must have a property interest rising to the level of an entitlement. *E.g.*, *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 577 (1972). Such property interests are created and defined "by existing rules or understandings that stem from an independent source such as state law." *Id.* The petitioners apparently assert a right not to

pay premiums at rates higher than the initial premiums. However, "[t]he policies in the record that were issued in [the 1983-85] period all state explicitly that the rates charged in those policies are 'provisional'" (Pet. App. A9) (decision of the Supreme Judicial Court). This fact disposes of petitioners' procedural due process claim as to the DPL Statute. *See Weaver v. Graham*, 450 U.S. 24, 29-30 (1981) ("Evaluating whether a right has vested is important for claims . . . under the Due Process Clause[], which solely protect[s] pre-existing entitlements."); *Great Northern Ry. Co. v. Sunburst Oil & Refining Co.*, 287 U.S. 358, 362 (1932)(no denial of due process to require carrier to refund a portion of rates made provisional by statute).

Moreover, even if a protected interest existed, the provisions of the DPL statute delaying and spreading the collection of the difference between the provisional and final premiums over five years are not subject to procedural due process challenge. "[T]he legislative determination provides all the process that is due." *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982). See *Bi-Metallic Inv. Co. v. State Bd. of Equalization*, 239 U.S. 441, 445-46 (1915).

2. The petitioners also challenge the potential application of the Recoupment Statute after conclusion of the pending administrative proceeding. With respect to this statute, their claim that the due process issue is "important" (Pet. 7) is subject to two responses.

First, to the extent petitioners assert that they should not be burdened for past deficits, they make a substantive due process challenge, and that issue was waived by petitioners' dismissal of the count of their complaint raising that claim (Pet. App.

A9)(opinion of the Supreme Judicial Court). Where the substantive due process claim was voluntarily dismissed in the trial court, the issue has not been properly "specially set up or claimed" within the meaning of 28 U.S.C. 1257(a). It is accordingly not before the Court. *Cf. Beck v. Washington*, 369 U.S. 541, 549-50 (1962)(argument not made in trial court "is not properly before this Court").[3]

Second, petitioners' argument does not accurately reflect the workings of the Recoupment Statute, which only operates prospectively. As amended, the statute permits application of a separate recoupment rate to all policyholders in a future year, regardless of whether the policyholders were even in business in the deficit year. The statute thus does not operate

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[3] Even assuming that petitioners could raise a substantive due process issue, the mere fact that a burden is being imposed on account of past actions does not make a statute arbitrary in violation of due process. See *Pension Benefit Guaranty Corp. v. R.A. Gray & Co.*, 467 U.S. 717, 733-34 (1984)(not arbitrary to require withdrawing employer to compensate pension plan for benefits vested at time of employer's withdrawal); *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 19-20 (1976)(not irrational to require mine operators to provide compensation for former employees' injuries arising out of employment even if employment terminated prior to legislation). In this case the purported "burden," the potential recoupment of deficits for the 1975-82 years, simply represents the amounts necessary to assure the continued existence of the MMPIA and thus the availability of medical malpractice insurance in the Commonwealth. The existence of the MMPIA benefits all physicians and hospitals in the Commonwealth and thus they may rationally be required to pay for a deficit. See *Risk Management*, 407 Mass. at 505, 554 N.E.2d at 848.

retrospectively.

3. The petitioners appear to assert that the Supreme Judicial Court's decision conflicts with this Court's decisions in *Railroad Retirement Board v. Alton R. Co.*, 295 U.S. 330 (1935), and *Smith v. Illinois Bell Telephone Co.*, 270 U.S. 587 (1926)(Pet. 7, 9). Neither case bears on the matter at hand. Indeed, the petitioners concede that "neither of the[] inadequate rate situtations [in *Alton* and *Smith*] is what confronts the Petitioners here" (Pet. 9).

In *Alton*, the Court applied substantive due process or takings principles to hold the Railroad Retirement Act of 1934 unconstitutional as a deprivation of property. See *Alton*, 295 U.S. at 349 (holding that "[i]t is arbitrary in the last degree" to burden railroads with pensions for those who had left service prior to the legislation and rejecting the argument that "such largess" will promote efficiency or safety as "without support in reason or common sense"). As noted above, petitioners have waived such claims. In any event, even assuming that this aspect of *Alton* "retains vitality," see *R.A. Gray*, 467 U.S. at 733; *Turner Elkhorn*, 428 U.S. at 19, the situtation here, like those in *R.A. Gray* and *Turner Elkhorn*, is clearly distinguishable from that in *Alton*.

Petitioners claim that their settled expectations have been upset (Pet. 9) and focus on the language of *Alton* concerning the imposition for the future "of a burden never contemplated by either party" (Pet. 7 (quoting *Alton*, 295 U.S. at 349)). However, the parties to the insurance contracts plainly contemplated that the petitioners might bear the costs that they now challenge. The statute in effect at the time the MMPIA and insureds entered into the 1975-82 policies specifically

provided that the MMPIA was a "self supporting entity" and established a mechanism or mechanisms for recoupment of deficits from policyholders. St. 1975, c. 362, § 6, second par, seventh par (as originally enacted and as amended). Petitioners thus have no reliance interests of the type recognized in *Alton*. *See Atkins v. Parker*, 472 U.S. 115, 130 (1985) ("All citizens are presumptively charged with knowledge of the law.").[4]

Petitioners' reliance on *Smith* is equally misplaced. In that case, a utility operating under a schedule of confiscatorily low rates had filed a schedule of increased rates which the Commerce Commission refused to act upon. 270 U.S. 589-90. The Court held that "long-continued and unreasonable delay in putting an end to confiscatory rates" deprived the utility of property in violation of due process. *Id.* at 591. Petitioners assert that "there is no meaningful difference between rates which are so low as to be confiscatory, and insurance premiums which are so excessive as to be confiscatory" (Pet. 9). However, petitioners assert a delay-based claim, and there is a great difference between delay that deprives a claimant of property in the meantime (as in *Smith*) and a delay where the claimant holds property (as here). Petitioners had the use of monies until assessment of the separate DPL rates under the DPL statute, and they still have the use of monies pending a determination whether a deficit exists and whether any rate

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[4] With respect to the DPL Statute, of course, the insurance policies themselves provided that the initial 1983-84 and 1984-85 rates which the petitioners claim to have relied on were "provisional."

increases will be ordered under the Recoupment Statute.[5] They have thus suffered no confiscation of property.

4. In any event, even if they could invoke the Due Process Clause, petitioners must establish that delay in an administrative proceeding is "unreasonably prolonged" to establish a violation of due process. *Cleveland Board of Education v. Loudermill*, 470 U.S. 532, 547 (1985) (9-month delay, of itself, "does not state a claim of constitutional deprivation."). The significance of a delay "cannot be evaluated in a vacuum." *Federal Deposit Ins. Corp. v. Mallen*, 486 U.S. 230, 242 (1988). The petitioners have not even specified the delay of which they complain, let alone articulated any ground for thinking that the delay was unreasonable. This fact-intensive issue would require analysis of the Commissioner's ratesetting proceedings and the pending recoupment proceeding. These matters are not of sufficient general importance to warrant review.

II. PETITIONERS' CONTRACTS CLAUSE ARGUMENT DOES NOT MERIT REVIEW BY THIS COURT.

In the portion of their petition devoted to their Contracts Clause question, petitioners do not even address the substance of the Supreme Judicial Court decision, let alone assert that it conflicts with any decisions of this Court. Review by this Court is not warranted because petitioners waived the question of the constitutionality of the DPL Statute, and the Supreme

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[5] Similarly, the petitioners had the use of monies until assessment of the separate DPL rates under the DPL Statute.

Judicial Court's decision accords with decisions of this Court. Even on petitioners' terms, however, review is not warranted because the appeal presents questions of state law that lack broad importance.

1. To the extent petitioners' second question purports to present a challenge to the DPL Statute on Contracts Clause grounds, was waived both by petitioners' failure to argue it in the trial court and by their failure to argue the issue in their principal brief on appeal as required by Rule 16(a)(4) of the Massachusetts Rules of Appellate Procedure (Pet. App. A6 n.4)(opinion of the Supreme Judicial Court). The petitioners thus failed to properly "draw in question" the validity of the DPL Statute on this ground before the State courts. See 28 U.S.C. § 1257(a). In light of this waiver, the issue is not preserved. See *Beck v. Washington*, 369 U.S. at 551-52, 553.[6]

2. Petitioners do not advance any argument directed at the holding of the Supreme Judicial Court that the Recoupment Statute, St. 1980, c. 333, does not operate retroactively (Pet. App. A7-A8). That statute continued the provision for recoupment by prospective rate increases originally enacted by St. 1975, c. 362, § 6, seventh par., and it only operates prospectively. Under the statute, recoupment liability is shared by all "policyholders" in the future rate year, and it is

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[6] In any event, the initial premium rates on which the petitioners rely in challenging the DPL Statute were provisional under the express terms of the policies for 1983-85. Revision of such rates thus does not impair the contracts. See *Weaver*, 450 U.S. at 29-30; *Great Northern Ry.*, 287 U.S. at 362.

independent of any prior contractual relationship between a physician and the MMPIA. The Legislature "opted for a method of collection which would look to the future, rather than the potentially more burdensome method of examining past activity for liability purposes." *Risk Management*, 407 Mass. at 504 n.6, 554 N.E.2d at 847 n.6.

The Contract Clause, however, "applies only to laws with retrospective, not prospective, effect." *Local Div. 589, Amalgamated Transit Union v. Comm. of Mass.*, 666 F.2d 618, 637 (1st Cir. 1981)(citing *Ogden v. Saunders*, 25 U.S. (12 Wheat.) 213 (1827)), *cert. denied*, 457 U.S. 1117 (1982). By the statute's terms, any recoupment will affect rates only in a future year and will apply to policyholders and policies in that future year. Since the Recoupment Statute was effective before any annual insurance policy to which a recoupment obligation may attach was made, the Contract Clause is not implicated. See *Watson v. Employers Liability Assur. Corp.*, 348 U.S. 66, 70 (1954) (impairment of contract claim is "wholly devoid of merit" where "the direct action provisions [of the statute] became effective before the insurance contract was made").

3. The Supreme Judicial Court's decision made it unnecessary to reach the issue whether the policies from 1975 to 1980 contain, as petitioners contend, a term that purportedly prohibits recoupment by prospective rate increases and limits the MMPIA to recoupment by means of assessments. The Supreme Judicial Court did state that "[i]t cannot be the case that by entering into its insurance policies the MMPIA restricted the Legislature's ability to authorize any future deficit recoupment method *not specified in the policies*" (Pet. App. A7)(emphsis added). Contrary to the petitioners' assertion

(Pet. 10-11), however, there is no such agreement in the policies, which reserve the right to recoup by assessment but are silent with respect to recoupment by prospective rate increases. No language in the pre-1981/82 policies purports to limit the means by which the MMPIA may recoup any deficit.[7] The contracts thus do not contain the provision on which plaintiffs' Contracts Clause argument depends. *Cf. Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 246 n. 18 (1978) (challenged law "nullified an express term of the pension plan"). Moreover, the law in effect at the time the policies were entered specifically allowed recoupment "by a rate increase applicable prospectively." St. 1975, c. 362, § 6, seventh par. In light of the specific provisions of the statute, petitioners cannot show any contractual right to avoid recoupment by prospective rate increase in future years. *Cf. General Motors v. Romein*, U.S. , 112 S. Ct. 1105, 1110 (1992) (petitioners "have not shown that the alleged right to rely on past payment periods as closed was part of Michigan law at the time of the original contract").

4. Even if the insurance policies contained the term on which the petitioners puport to rely, the Contracts Clause issue does not warrant review because the petitioners' only claim of "substantial" impairment rests on speculation. Petitioners

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[7] The policies' silence concerning recoupment by increases in prospective rates is not surprising. Recoupment by prospective rates by definition does not affect premium rates for the policies for a deficit year but only for the rate year(s) in which recoupment is sought. Thus, a reference to recoupment by assessment does not imply any prohibition of recoupment from future policyholders by rates payable in future years.

claim only one harm from the alleged impairment: that as policyholders in a future year when a prospective rate increase to pay for a deficit is imposed they may be members of a smaller pool than if the deficit had been recouped by an assessment on the policyholders in the deficit year (Pet. 14-15). However, as the Supreme Judicial Court pointed out (Pet. App. A12), there is no evidence in the record concerning any change in the size of the pool of policyholders over time, and this claim is purely speculative.

Moreover, in determining the extent of any impairment, a primary consideration is "whether the industry the complaining party has entered has been regulated in the past." *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411 (1983); *see Veix v. Sixth Ward Bldg. & Loan Ass'n*, 310 U.S. 32, 37-38 (1940).[8] In this case, not only was medical malpractice insurance the subject of extensive regulation under St. 1975, c. 362,[9] but the law at the time petitioners entered the contracts at issue specifically allowed the form of recoupment they now protest. *Id.*, § 6, seventh par.

5. Finally, if there were a substantial impairment, review is not warranted because of the clear public benefit of the

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[8] As noted at page 6, above, the petitioners are simply wrong in asserting that the Commonwealth is self interested. The Commonwealth was not a party to the contracts and has no obligations under them.

[9] Prior to enactment of Mass. G.L. c. 175A, § 5A, by St. 1975, c. 362, § 4, medical malpractice insurance rates were regulated under existing provisions of Mass. G.L. c. 175A.

statute. The Legislature may exercise its police power for the general good of the public even if it affects contracts previously entered. *Energy Reserves Group*, 459 U.S. at 411-12. If the MMPIA is to continue to smooth the operation of the medical care marketplace, then there has to be a way to recoup deficits; otherwise, it eventually would be unable to continue to function in the face of a deficit. The Legislature choose to impose potential recoupment liability on all doctor or hospital "policyholders," whether or not insured by the MMPIA, as a condition of licensure. That determination was a broad exercise of the police power to impose a "generally applicable rule of conduct" on all doctors and hospitals in the Commonwealth, and it did not simply readjust the rights of the contracting parties. *See Exxon Corp. v. Eagerton*, 462 U.S. 176, 192 (1983). Rather, the Legislature removed the potential (and annually increasing) burden of recoupment by assessments from past MMPIA insureds and continued (or, as the petitioners contend, substituted) a recoupment obligation on all policyholders in a future year. This amendment eliminated the practical and administrative burdens of determining and obtaining assessments based on past insurance policies. Those who pay recoupment liability will do so in the context of actual ongoing medical practices. The statute thus appropriately furthers the important goals of ensuring the availablity of medical malpractice insurance and of medical services. In so acting, the Legislature clearly sought to remedy "a broad and general social or economic problem." *Energy Resources Group*, 459 U.S. at 412.

Conclusion

For the reasons stated above, the petition for a writ of certiorari should be denied.

LINDA RUTHARDT, AS COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS, AND THE COMMONWEALTH OF MASSACHUSETTS

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